Hearing HealthCare Centers

Patient Name:_____ **Date of Birth:** _____

Privacy Notice For Our Office

Our pledge to you. We understand that your medical information is personal and confidential. Our ethics and policies require that your information be held in strict confidence. We are committed to protecting your personal healthcare information in accordance with the law.

We have posted our privacy statement on our bulletin board as required by law. If you have any questions, or to request a copy, please contact a Patient Care Coordinator at any Hearing HealthCare Center Office.

I have read and understand the above.

Signature _____ **Date** _____

Cerumen Management Waiver

I give permission to Hearing HealthCare Centers to remove cerumen (ear wax) from my ears, as deemed appropriate. I understand that occasionally redness, soreness and in rare cases, minor bleeding can occur.

I agree not to hold the professional or the clinic liable if any of the above-mentioned symptoms occur.

I agree to inform the professional of any blood thinning medications I am currently taking.

Please list: _____

_____

_____

_____

Signature: _____ **Date:** _____

Boulder	**Broomfield**	**Colorado Springs**	**Ft Collins**	**Loveland**	**Longmont**
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