Audiological Services
601 Ellis AVE
Lufkin, TX 75904
(936) 632-2252
MAIN OFFICE

All About Hearing
2703 W Cuthbert AVE
Midland, TX 79701
(432) 689-2220

Central Texas Hearing Center
1320 Wonder World DR, #107
San Marcos, TX 78666
(512) 667-7921

Central Texas Hearing Center
1927 Lohman's Crossing Rd., Ste 203
Lakeway, TX 78734
(512) 640-2999

CERUMEN REMOVAL CONSENT FORM

Date:_____

Patient Name:_____

Date of Birth:_____

TO THE PATIENT*: *You have the right, as a patient, to be informed about your condition and the recommended procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

Cerumen, also known as ear wax, is produced by glands in the ear canal, and typically comes out of the ear on its own. Cerumen helps trap debris in the ear canal before it reaches the eardrum. When an ear produces too much cerumen, it can harden in the ear canal and cause a blockage (impaction). The use of Q-tips and hearing aids can also cause an impaction by pushing the ear wax further into the ear canal.

Your audiologist may decide it would be best to remove ear wax from your ear canal. Your audiologist will take precautions to avoid discomfort or adverse results.

I voluntarily request Leah Guempel, Au.D., CCC-A ("Provider") as my health care provider and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition which has been explained to me (us) as: cerumen impaction._____

I understand that the Provider plans to perform Cerumen Removal and I voluntarily consent and authorize these procedures.

I understand that no warranty or guarantee has been made to me as to result or cure.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the procedures planned for me. I (we) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also realize that the following risks and hazards may occur in connection with this particular procedure Certain risk factors may make it more likely for you to incur complications such as bleeding and irritation. These complications may occur even if you have no risk factors. Complications and side effects of cerumen removal are rare, but may include:

- Cerumen remains: If your audiologist is unable to remove the cerumen, you will be directed to see your primary care provider or otolaryngologist (ENT) for further treatment.
- Discomfort: Some people may feel mild to moderate discomfort during the procedure.

- Injury to the ear canal: Abrasions to the ear canal may occur during cerumen removal. Some bleeding may occur during the procedure. Bleeding is usually slight and resolves on its own. In rare cases, you may suffer temporary hearing loss, infection, dizziness, and tinnitus

At any point during cerumen removal, I may request the procedure be stopped. I have been informed of my condition and consent is hereby voluntarily given for cerumen (earwax) removal.

I have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of nontreatment, the procedures to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this consent.

I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents.

By signing this form of consent, you are agreeing to release LG Audiological Enterprises, LLC, its owners, officers, directors, employees and representatives from any complications arising from the removal of ear wax from your ear canal as explained above. You represent and warrant that you have the right, power, legal capacity, and requisite authority to enter into this consent and release and will sign any additional documents to make its provisions fully effective. You acknowledge that you have read and voluntarily enter into this consent and release and understand its meaning and acknowledge that it is binding upon you, your legal representative, heirs, and assigns.

DATE: _____ TIME: _____ A.M./P.M.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON:

_____

(Signature required)

_____

Responsible Person or Parent Name (Print)

_____

Patient or Responsible Person Address (Street or P.O. Box) City, State, Zip Code

WITNESS Printed Name:_____

_____

Witness Signature