BECKER
EAR, NOSE & THROAT CENTER

Contract for Evaluation and Treatment

I understand that as part of my medical care, my Becker ENT physician may prescribe or recommend various medications. I understand that any medication may have unintended side effects, interactions, and complications, sometimes in combination with other medications. Most of these are discussed on the medication inserts. I agree to read these inserts so that I understand the risks associated with any prescribed medication. I agree to ask my Becker ENT physician at my appointment, or by phone after my appointment if I have any further questions about the prescribed or recommended medications. I agree that I will not take any medications until my questions have been answered in a manner that is satisfactory to me.

My Becker ENT physician may also prescribe for me to have further evaluation such as a blood work, cultures, CT scan, MRI, or a hearing and/or balance test. He may also recommend further evaluation by a gastroenterologist, laryngologist, neurologist, head and neck surgeon, or other medical specialist. I understand that further evaluation is often recommended to make sure that I do not have a condition that could threaten my health. This includes conditions such as tumors, cancers, and malignancies.

I understand that for any prescribed or recommended blood test, cultures, imaging test (CT, MRI), or evaluation (balance/hearing test) I should not consider this evaluation complete until I follow up with my Becker ENT physician to review the results of these test/evaluations. In the case of referral to another specialist I also understand that it is my (the patient's) responsibility to arrange and attend this appointment. If I have any difficulty doing so I will contact my Becker ENT physician and ask for assistance. Again, I understand that these evaluations and referrals are often recommended to make sure that I do not have a condition that could threaten my health. This includes conditions such as tumors, cancers, and malignancies.

Patient Name (Print)	Patient Signature	Date

Physician Name (Print)	Physician Signature	Date