



CALIFORNIA EAR INSTITUTE

San Ramon Palo Alto Santa Rosa

I acknowledge receipt of and the opportunity to review the following documents pertaining to my visit to the California Ear Institute (CEI) / California Sinus Institute (CSI) / Let Them Hear Foundation (LTHF):

- CEI/CSI/LTHF Clinic Business Policies (Effective 3/1/2008)
- CEI/CSI/LTHF Non-Standard Appointment Policy (Effective 3/1/2008)
- CEI/CSI/LTHF Email and Telephone Call Policies (Effective 3/1/2008)
- CEI/CSI/LTHF Notice of Privacy Practices (Effective 3/1/2008)

I understand that acceptance of these terms is a condition of receiving care at CEI/CSI/LTHF

By signing this document, I attest that all of the information I have provided to CEI/CSI/LTHF is true to the best of my knowledge, and that I will notify CEI/CSI/LTHF of any changes.

_____	_____	_____	_____
Patient Signature	Date	Witness	Date

Title (if signed by someone other than Patient)

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