



## Cerumen Removal Waiver

Your audiologist may determine that cerumen (i.e., ear wax) needs to be removed from your ear canal. The procedure can be done via irrigation (i.e., water) or manual removal. Due to its potential risks, this procedure should always be performed by a professional. Certain factors can increase the likelihood of complications, such as bleeding and irritation, although complications may still occur without these factors.

I give permission to The Hearing Doctor to remove cerumen from my ears as deemed appropriate. I understand that redness, soreness, and minor bleeding can occasionally occur. The process of ear wax removal can also involve discomfort, temporary hearing loss, and tinnitus. I agree to inform the professional of any blood thinning medications I am currently taking. You have the right to stop the procedure at any time. I agree not to hold the professional or the clinic liable if these symptoms occur.

By signing this consent form, you agree to release The Hearing Doctor from any complications arising from ear wax removal. You affirm that you have the authority, legal capacity, and power to enter into this consent and release, and you will sign any additional documents needed to ensure its full effectiveness. You acknowledge that you have read this consent and release, understand its meaning, and agree that it is binding upon you, your legal representatives, heirs, and assigns.

**Note:** Medicare does not pay for cerumen removal so you will be responsible for payment. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. If you choose to have this service, by signing this waiver, you should expect Medicare will not pay for the cerumen removal. You have the right to deny this service.

I fully understand and accept the terms of this consent with my signature.

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

**For Office Use Only:**

( ) Consent received by: \_\_\_\_\_ on:

( ) Consent refused by patient, and treatment refused as permitted.

( ) Consent added to the patient's medical record on \_\_\_\_\_.

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