|  |  |  |
| --- | --- | --- |
| 1150 AMBOY AVENUE  EDISON, NJ 08837  TEL: 732-548-3200  FAX: 732-548-4040 | 203 ROUTE 9 SOUTH  MARLBORO TWP, NJ 07726  TEL: 732-617-1800  FAX: 732-617-9743 | 5 MOUNTAIN BLVD SUITE 7  WARREN, NJ 07059  TEL: 908-222-8440  FAX: 908-222-8122 |

**PROCEDURE INFORMED CONSENT**

I understand that my doctor may perform one or more small procedures as

part of any office visit. These procedures may include wax removal, hearing

test, or visualization of the nose and throat with order to complete a full

evaluation of symptoms, and as a specialist, these tests can provide valuable

diagnostic information than can ultimately help my condition. I therefore give

consent to have these diagnostic procedures done so that I have the best chance

possible of having a successful treatment course.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

(office staff)