



Client Consent for Ancillary Health Care Consults

Client: _____ **Date:** _____

The above client desires to have in-house appointments with the following ancillary health care providers:

Audiologist (annual)

Declined

Previous/current audiologist: _____

Ophthalmologist (annual)

Declined

Previous/current ophthalmologist: _____

Podiatrist (approximately every 3-4 months)

Declined

Previous/current podiatrist: _____

I understand that I am responsible for payment of any and all fees incurred through the use of these services.

Responsible Party Signature

Date

Client Signature

Date