EASTERN SHORE ENT & Allergy ASSOCIATES, P.A.
JAMES R. GAUL · MICHAEL J. KELLEHER · DANIEL J. KELLEY | M.D., F.A.C.S.
Offices located in Salisbury & Berlin
phone: +1 (410) 742-1567 fax: +1 (410) 742-1906

Language Interpretation *Patient* Consent

Patient Name:_____ DOB:____/____/_____

Eastern Shore ENT and Allergy is committed to ensuring equal access regardless of national origin/language barriers and will ensure effective communication is achieved with all patients. Easter Shore ENT and Allergy maintains discretion over how to achieve effective communication.

I understand that if I need language interpretation, I will be asked to contact my health insurance or federally funded community based health clinic provider to arrange for language interpretation during the patient's office visit as provided as part of their benefits. Information about the interpreter will be collected and entered into my electronic medical record as a scanned document. The interpreter will be asked to sign a form stating they provided language interpretation services for the patient. I will be asked to sign a consent form stating I received language interpretation services. I understand that errors of interpretation can be made by well-intentioned interpreters. These errors have potential clinical consequences with regard to informed consent. I understand that language interpreters are not medical professionals and may not be able to adequately interpret complex medical concepts in an unbiased and independent fashion during the delivery of health care services.

I understand that Eastern Shore ENT and Allergy shall be blameless and not be held responsible for any errors in language interpretation which may occur as a result of providing medical services. Furthermore, as part of the consent process, and in order to provide continuity of care, I and the interpreter will be required to sign a consent form and the interpreter must be available during the entire process of providing medical care, including office visits, procedures, and in the post-procedure period.

I have the option of using family and/or friends as interpreters. This should occur only if I have requested language interpretation assistance as outlined above and this request has been declined in writing and documented in my record. **Family and friends who provide language interpretation must be 18 years of age or older and shall be required to fulfill the same requirements as a language interpreter as outlined above.** I understand that friends and family who act as language interpreters during the delivery of health care services are not medical professionals and may be unable to adequately interpret complex medical concepts in an informed, unbiased, and independent fashion.

Eastern Shore ENT and Allergy shall be blameless and not be held responsible for any errors in language interpretation which may occur as a result of a lack of availability of the language interpreter while providing medical services. If the designated language interpreter is not available at the time of office visit or procedure, the office visit or procedure will be re-scheduled when the language interpreter is available.

If a language interpreter cannot be provided by me, my insurance plan, or my federally funded community health organization, Eastern Shore ENT and Allergy will pay interpreters based upon 15 minute increments at a rate to be determined prior to my office visit and will not pay for travel time or interpreters who are family members or friends of the patient.

I understand Eastern Shore ENT and Allergy's Language Interpretation Policy and hereby give my permission for use of language interpreter services for the purposes of communicating medical information. I understand that the interpreter will have access to my medical information, only through the interpretation of this information. I understand that the interpreter will NOT have access to my written medical records.

_____		_____	
Patient Signature	Date	Interpreter Signature	Date
_____		_____	
Witness Signature	Date	Provider Signature	Date

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Language *Interpreter* Consent

Patient Name:_____ **DOB:**____/____/____

Eastern Shore ENT and Allergy is committed to ensuring equal access regardless of national origin/language barriers and will ensure effective communication is achieved with all patients. Easter Shore ENT and Allergy maintains discretion over how to achieve effective communication. I understand that I will provide language interpretation for the patient named above.

Information about me will be collected and entered into the patient's electronic medical record as a scanned document.

I understand that errors of interpretation can be made during the interpretation process and these errors have potential clinical consequences with regard to informed consent. I agree that I am not medical professional and may not be able to adequately interpret complex medical concepts in an unbiased and independent fashion during the delivery of health care services. I understand that Eastern Shore ENT and Allergy shall be blameless and not be held responsible for any errors in language interpretation which may occur as a result of providing medical services.

Furthermore, as part of the consent process, and in order to provide continuity of care, I agree to be available during the entire process of providing medical care, including office visits, procedures, and in the post-procedure period.

Eastern Shore ENT and Allergy shall be blameless and not be held responsible for any errors in language interpretation which may occur as a result of a lack of availability of the language interpreter while providing medical services. If I am not available at the time of office visit or procedure, the office visit or procedure will be re-scheduled when I am available.

I understand Eastern Shore ENT and Allergy's Language Interpretation Policy as it applies to me for use of language interpreter services for the purposes of communicating medical information.

I understand that I will have access to the patient's medical information and I will honor the patient's medical privacy as designated by Health Insurance Portability and Accountability Act of 1996.

_____ _____ _____ _____

Patient Signature Date Interpreter Signature Date

_____ _____ _____ _____

Witness Signature Date Provider Signature Date