

## LANGUAGE INTERPRETATION PATIENT CONSENT

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Eastern Shore ENT & Allergy is committed to ensuring equal access for all patients, regardless of national origin/language barriers, and will ensure effective communication is achieved with each one. Eastern Shore ENT & 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 my office visit, as provided as part of my 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 that they provided language interpretation services for me. I will be asked to sign a consent form stating that 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 & Allergy shall be blameless and not be held responsible for any errors in language interpretation that may occur as a result of providing medical services. Furthermore, as part of the consent process and to provide continuity of care, the interpreter and I will be required to sign a consent form. The interpreter must be available during the entire process of providing medical care, including during office visits, procedures and 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 if 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 & Allergy shall be blameless and not be held responsible for any errors in language interpretation that 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 the office visit or procedure, the office visit or procedure will be rescheduled for a time 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 & Allergy will pay interpreters in 15-minute increments at a rate to be determined before my office visit. It will not pay for travel time or interpreters who are family members or friends of the patient.

I understand Eastern Shore ENT & Allergy's Language Interpretation Policy and hereby give my permission for the 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

*Revised June 2019*

## LANGUAGE INTERPRETER CONSENT

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Eastern Shore ENT & Allergy is committed to ensuring equal access for all patients, regardless of national origin/language barriers, and will ensure effective communication is achieved with each one. Eastern Shore ENT & 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 that these errors have potential clinical consequences with regard to informed consent. I agree that I am not a 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 & Allergy shall be blameless and not be held responsible for any errors in language interpretation that may occur as a result of providing medical services.

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

Eastern Shore ENT & Allergy shall be blameless and not be held responsible for any errors in language interpretation that 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 an office visit or a procedure, the office visit or procedure will be rescheduled for a time when I am available.

I understand Eastern Shore ENT & Allergy's Language Interpretation Policy as it applies to me for the 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 that I will honor the patient's medical privacy as designated by the Health Insurance Portability and Accountability Act of 1996.

\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_  
Interpreter Signature Date

\_\_\_\_\_  
Witness Signature Date

\_\_\_\_\_  
Provider Signature Date

*Revised June 2019*