PATIENT POLICIES & CONSENT

SELECT HEARING
1408 I-70 Dr. SW #102, Columbia, MO 65203

PATIENT NAME: _____

PATIENT PRIVACY POLICY: I have been informed of and have available to me, Select Hearings' complete *Notice of Privacy Practices* pursuant to HIPAA. The Notice provides information about how we may use and disclose the medical information that we maintain about you, and we encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the clinic and on the website, and any revised *Notice of Privacy Practices* will be made available. I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* at any time.

AUTHORIZATION FOR RELEASE OF INFORMATION: I give permission to Select Hearing to release my protected health information (PHI), verbal and written, contained in my medical record to my health insurance company, related healthcare providers, Select Hearing's business associates, and to the following individuals, if applicable:

_____ _____

Name of Individual Relationship to Patient

All other requests for information must be submitted in writing to Select Hearing by the patient or assignees.

CONSENT TO SERVICES: I consent to receive audiological services from Select Hearing. This consent encompasses audiological services including, but not limited to, diagnostic testing and evaluations, device fittings and adjustments, device cleanings, ear mold impressions, and/or any other services that is/are required for my appointment(s). I understand that this consent form will be valid and remain in effect as long as I receive audiological services from Select Hearing.

CONSENT TO BILL: I acknowledge and agree that regardless of my health insurance status, I am responsible for the balance of my account to be paid in full on the Date of Service for professional services rendered and/or purchases made. I authorize Select Hearing to obtain information related to my insurance benefits and to submit all billing invoices to my insurance company, if applicable.

COMMUNICATION AGREEMENT: I understand that Select Hearing will need to contact me by phone, email, and/or text for appointment scheduling, product information, and/or services provided as recorded in the *New Patient Intake Form*. All protected health information, i.e.; name and address, will never be sold.

PHOTO ID & INSURANCE: I agree to provide my driver's license, or other form of photo ID, and my insurance card(s) for Select Hearing to make copies of and maintain my record to prevent insurance fraud, false identification, and to ensure that your insurance is billed correctly.

I have read the above information and give Select Hearing permission to treat my concerns.

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Patient/Guardian Signature Date