# Hear Sarasota

Patient Name: _____
Date of birth: ____/____/_____
Phone:_____
Address: _____
City: _____
State: ____
Zip:_____
Marital Status: _____
Email: _____
Employment Status: □ Full-time □ Part-Time □ Retired □ Student
Name of Insured, if different than
Patient: _____
Date of Birth____/____/_____
Address if different than above_____
_____
Physician: _____
Address:_____
_____
Telephone: _____
Fax: _____

CONSENT, PRIVACY AND RELEASE FORM: I consent to receive audiological services from Hear Sarasota, LLC. This consent encompasses audiological procedures including, but not limited to, diagnostic testing, rehabilitative treatment, ear wax removal, and taking of ear mold impressions. I understand that this consent form will be valid and remain in effect as long as I receive audiological care from Hear Sarasota, LLC.

Patient Signature_____

Date ____/____/_____

Guardian/Power of Attorney Signature_____

Date ____/____/_____

In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical

record may be released to my physician, a designated referral physician and/or the provider, if any, who referred me here.

Patient Signature_____

Date ____/____/_____

I hereby authorize the release of any medical or other information necessary to process my insurance claim. I further authorize payment of medical benefits to Hear Sarasota, LLC for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office. This is to serve as a long-term authorization card.

Patient Signature_____

Date ____/____/_____

I hereby expressly acknowledge that the Advanced Audiology Consultants Notice of Patient Privacy Practice has been made available to me.

Patient Signature_____

Date ____/____/_____

Patient Authorization of Disclosure

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual’s office instead of the individual’s home. The patient may revoke or change this authorization at any time with a written request.

I wish to be contacted in the following manner (Check all that apply):

Home Telephone: □ O.K. to leave message with detailed information □

Leave message with call-back number only Work Telephone: □

O.K. to leave message with detailed information □

Leave message with call-back number only □

Do not call me at work Written Communication □

# Hear Sarasota

O.K. to mail to my home address □

O.K. to fax to my home fax: □ O.K. to email: □ OTHER: _____

Would you like to receive our newsletter? □ yes □ no Via: □ Email □ Mail

Would you like to receive information on promotional items? □ yes □ no Via: □ Email □ Mail

Please indicate any other family members with which you would like us to be able to communicate health, insurance, and/or financial information relating to your hearing health care.

Name: _____ Phone # _____

Relationship: _____ Patient

Signature_____ Date _____