Clear Choice Hearing and Balance

Consent for the use and Disclosure of Health Information

By signing this form, you are granting consent to Clear Choice Hearing and Balance to use and disclose your protected health information for the purpose of treatment, payment and coordination of care.

Our notice of Privacy Practices provides more detailed information about how we may use and disclose the protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice in the office. You have the right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment and coordination of care. We are not required by law to grant your request; however, if we agree to grant your requests for restrictions we will then be bound by that agreement.

You have a right to revoke this consent. Doing so must be in writing, except to the extent that health information has already been disclosed in reliance on you consent.

I Hereby:

_____Give Consent
_____Deny Consent

Print name of Patient:________________________________ Date of Birth: ______________________

Patient Signature: _________________________________Today's Date:______________________

Primary Care Physician:__________________________Phone # __________________________

Referring Physician :________________________________Phone# __________________________

I authorize the following person to have access to my health information

Emergency Contact:
Telephone Number:

Patient Name:___________________________________

Client Signature for insurance billing and authorization to release records / information

Clear Choice Hearing is a participating provider with many insurance companies. If you are insured with a private insurance carrier, we will submit a claim only if you provide us with the current and appropriate information and signature below.

I hereby authorize payment directly to Clear Choice Hearing for any services performed by the above. I hereby agree to pay Clear Choice Hearing for all reasonable charges. In the event that I fail to pay charges when due, and Clear Choice Hearing refers the amount to an attorney for collection, I agree to pay the cost of the collection including the attorney's fees.

I hereby authorize the release of any audiological medical records or reports to or from Clear Choice Hearing. The information may be released to my Primary Care Physician and/or referring physician or insurance company. A signed photocopy of this form may convey the above authorization.

Attn: ALL
CO-PAYS ARE DUE AT TIME OF SERVICE
A $10 FEE WILL BE ADDED IF YOU FAIL TO PAY

Signature :____**Date:**______________________

*********** **ATTENTION AFFORDABLE CARE ACT MEMBERS :**

I acknowledge as an Affordable Care Act Exchange Member, that I have been made aware I will solely be responsible for any and all charges incurred for services render by Clear Choice Hearing and Balance, should I default on my Insurance Premiums.

********Signature:**____________________________________**DATE:**________________

For Office use Only:

☐

Photo ID