

# Patient Consent & Acknowledgement Form

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

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

## Consent to Release Information

Authorization for Release of Protected Health Information to a Trusted Individual

\_\_\_\_\_ By initialing this paragraph, I authorize \_\_\_\_\_ to communicate with the Trusted Individual(s) named  
Initial below about my prognosis and treatment plans, diagnosis, test findings, reports and invoices related to my healthcare.

Physician Name: \_\_\_\_\_

Friend or Family Member

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## Consent to Communicate electronically between Patient and

By initialing this paragraph, I agree to receive appointment reminders, office information including but not limited to location information, hours of operation, change of address, hardware & software update notifications, real-time telehealth connectivity and recording, remote programming and counseling sessions, marketing information & promotions, diagnostic information, or other information or forms via the internet, email, or text.

\_\_\_\_\_ Initial

I agree that I will NOT use email or text to communicate any urgent matters to the staff of \_\_\_\_\_  
I understand that email sent from \_\_\_\_\_ is potentially accessible to third parties. I also understand that on my end, anyone who has access to my email account or my unsecured electronic devices will potentially have access to communication sent between \_\_\_\_\_ and myself.\*

## Good Faith Estimate

Treatment includes services as well as the hearing aid(s). The total investment depends on the services needed and the type of hearing aid(s) used for treatment. Costs can range from a few hundred to a few thousand dollars or more per hearing aid. This includes treatment plan services, office visits, as well as a manufacturer warranty on the hearing aid(s). The exact investment amount will be specified on a purchase agreement which also outlines the return privileges included with hearing aid(s) used in treatment of hearing loss.

\_\_\_\_\_ Initial

## Assignment of Benefits

I am aware that by initialing this section, I am authorizing \_\_\_\_\_ to bill my insurance benefits to be paid directly to \_\_\_\_\_. I also authorize the release of any information required to process this claim. I agree to accept final responsibility for all charges which are non-covered and thus not paid to \_\_\_\_\_ by my insurance carrier(s) for services rendered by \_\_\_\_\_.

\_\_\_\_\_ Initial

## Written Acknowledgment of Notice of Privacy Practices Offered

\_\_\_\_\_ By initialing this paragraph, I acknowledge that I have been offered a copy of  
Initial Notice of Privacy Practices.

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_