Alliance Hearing Center LLC
Alliance Hearing Aids LLC

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HIPAA Disclosure, Release of Information, Consent, Communication, Photo ID

Please read and initial each policy statement and sign the bottom of the form.

PATIENT PRIVACY POLICY: I acknowledge that a copy of the Alliance Hearing Center LLC and/or Alliance Hearing Aids LLC patient privacy policy was offered or given to me. (Available at check-in window and on our website.)

Initials: ____________

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize the release of information to my audiologist, any physician involved in my care, as well as to my insurance company to process my medical claims.

Initials: ____________

CONSENT: I authorize Alliance Hearing Center LLC and/or Alliance Hearing Aids LLC and any qualified, authorized person employed by them to perform and/or initiate diagnostic evaluation and hearing aid treatment and authorize or order related services and agreed upon products on my behalf.

Initials: ____________

COMMUNICATION AGREEMENT: I understand that as part of my hearing healthcare, Alliance Hearing Center LLC and/or Alliance Hearing Aids LLC will need to contact me in order to schedule an appointment, remind me of an appointment, provide test results, give instructions or provide other information. I have indicated my preferred method of contact on the registration form.

Initials: ____________

PHOTO ID: Due to new government regulations regarding insurance fraud and mistaken identity as well as Meaningful Use requirements with our new Electronic Medical Record system, we will be taking webcam photos of our patients (parent & child for a patient who is an infant/toddler). In addition, patients and/or guardians may be asked for a driver's license or other photo ID.

Initials: ____________

My signature below acknowledges that I have read and agree to the above listed policies.

____ ____________________

Signature of Patient/Legal Guardian Date