CONSENT FOR TREATMENT

Name: ____

Parent's/Guardian Name if Patient is a Minor:________________________________

Address: ________________________________ City: _________________________

State: __________ Zip Code: ____________ Age: _____ Date of Birth: __________

Phone: Work________________ Home ___________________ Cell _____________

Referred By ____

We appreciate the opportunity to assist you in your pursuit of better hearing and promise to provide quality service in any way we can. Although we are happy to work with your insurance provider, patients are ultimately responsible for their bill. In most cases, payment is required at time of service.

Please note: Medicare does <u>not</u> provide coverage for hearing aids, batteries, or repairs.

Consent for treatment:
By signing below, I give my consent for examination and treatment for myself. If patient is a minor, by signing I give consent for examination and treatment for the above minor patient.

Consent for Use and Disclosure of Protected Health information:
I hereby give my consent for Accurate Hearing Systems, LLC to use and disclose of protected health information (PHI) about me to carry out treatment, payment and health operations. (The Notice of Privacy Practices provided to me describes such uses and disclosures more completely).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Accurate Hearing Systems, LLC reserves the right to revise the Notice of Privacy Practices at any time.

Signature: _____________________________________ Date: ________________