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

_____
Initial

By initialing this paragraph, I authorize Professional Hearing Solutions by Dr. Jill to communicate with the Trusted Individual(s) named 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

_____
Initial

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.

I agree that I will NOT use email or text to communicate any urgent matters to the staff of Professional Hearing Solutions by Dr. Jill. I understand that email sent from Professional Hearing Solutions by Dr. Jill 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 Professional Hearing Solutions by Dr. Jill and myself.*

Good Faith Estimate

_____
Initial

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.

Assignment of Benefits

_____
Initial

I am aware that by initialing this section, I am authorizing Professional Hearing Solutions by Dr. Jill to bill my insurance benefits to be paid directly to Professional Hearing Solutions by Dr. Jill. 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 Professional Hearing Solutions by Dr. Jill by my insurance carrier(s) for services rendered by Professional Hearing Solutions by Dr. Jill.

Written Acknowledgment of Notice of Privacy Practices Offered

_____
Initial

By initialing this paragraph, I acknowledge that I have been offered a copy of Professional Hearing Solutions by Dr. Jill's Notice of Privacy Practices.

Signature: _____ Date: _____ / _____ / _____

***Professional Hearing Solutions by Dr. Jill is committed to keeping your email address confidential.**