Patient Name:_____ **Date of Birth:**_____

Privacy Notice For Our Office

Our pledge to you. We understand that your medical information is personal and confidential. Our ethics and policies require that your information be held in strict confidence. We are committed to protecting your personal healthcare information in accordance with the law.

We have a copy of our privacy statement in our privacy folder as required by law. If you have any questions, or to request a copy, please contact the Patient Care Coordinator at Professional Hearing Solutions By Dr. Jill.

I have read and understand the above:

Signature:_____ **Date:**_____

If we are contacted by someone that you know personally (example: spouse, parent, child), may we release information to them?

□ No, I prefer no information is released

□ Yes, information can be given to the alternate contact/contacts below:

Name: Relationship: Phone:

Information to be released to the alternate contact (please check all that apply):

□ Medical Information □ Appointment Dates/Times □ Financial Information □ Other : _____

Cerumen Management Waver

I give permission to Professional Hearing Solutions by Dr. Jill to remove Cerumen (ear wax) from my ears, as deemed appropriate. **I UNDERSTAND** that **occasionally redness, soreness and in rare cases, minor bleeding can occur. Also risk of possible infection and damage to ear canal/eardrum.**

I agree not to hold the professional or the clinic liable if any of the above mentioned symptoms occur.

I agree to inform the professional of any **BLOOD THINNING MEDICATIONS** I am currently taking.

Please List:

_____

_____

Signature:_____ **Date:**_____

Optional Communication (Emergency Only)

I give permission to Professional Hearing Solutions By Dr Jill to:

Send Text Communications: ☐ Yes ☐ No Cell - _____

Send Email Communications: ☐ Yes ☐ No Email -_____

Signature:_____

Date:_____