PROFESSIONAL HEARING SOLUTIONS by Dr. Jill

Patient Name: _____ Date of Birth: _____

_____ Initials **Consent to Release Information** ***Authorization for Release of Protected Health Information to a Trusted Individual***

By initialing this paragraph, I authorize PHS by Dr. Jill to communicate with the Trusted Individual(s) named below about my prognosis and treatment plans, test findings, reports and invoices related to my healthcare.

Physician Name: _____

***Trusted Individual(s):***

Name: _____ Relationship: _____ Phone No. _____

Name: _____ Relationship: _____ Phone No. _____

## Consent to Communicate Electronically Between Patient and PHS by Dr. Jill

_____ Initials 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. I understand that email sent by PHS 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 my communication sent between PHS by Dr. Jill and myself. *

## Good Faith Estimate

_____ Initials 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. Cost 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 manufacturer warranty on the hearing aid(s). The exact investment amount will be specified in a purchase agreement which also outlines the return privileges included with the hearing aid(s) used in treatment of hearing loss.

## Cerumen Management Waiver

_____ Initials I give permission to PHS by Dr. Jill to remove cerumen (ear wax) from my ears, as deemed appropriate. I understand that occasional redness, soreness and in rare cases, minor bleeding can occur, as well as the risk of possible infections and damage to the ear canal/ear drum. I agree not to hold the professional or the clinic liable if any of the above-mentioned symptoms occur.

## Assignment of Benefits

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

## Written Acknowledgement of Notice of Privacy Practices Offered

_____ Initials By initialing this paragraph, I acknowledge that I have been offered a copy of PHS by Dr. Jill's Notice of Privacy Practices.

Signature: _____ Date: _____ / _____ / _____

***PHS by Dr. Jill is committed to keeping your email address confidential***