Billing and Financial Statement, HIPPA Acknowledgement Receipt, Release of Medical Records, Policies

**HIPAA:**

By initialing this section and signing below, I accept and acknowledge that I may request to receive a copy Professional Hearing Services Inc Notice of Privacy Practices. The Notice provides information about how we may use and disclose health information for the purposes of treatment and/or payment; purposes for other than treatment and health care operations; and shared as required/permitted by law. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available. If we change our notice, you may obtain a copy by contacting Professional Hearing Services.

**Please Initial**____

**Communications:**

I authorize Professional Hearing Services to notify me of appointments, hearing aids/material pickups and any other such information via home phone, cell phone, email or text the numbers/email address that I provide. I further agree that a message may be left at home or cell phone numbers that I provide if I am not available. Professional Hearing Services will never use my information for marketing purposes outside of their offices.

**Please Initial**____

I authorize Professional Hearing Services to market/contact me regarding new services and/or treatment options that may further educate me regarding my hearing health.

**Please Initial**____

**Financial:**

We ask that all office visits and services be paid for at the time they are provided. Although we will gladly bill your insurance, when possible, you will be responsible for any unpaid balance by your insurance where applicable.

**Please Initial** ____

I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignments.

**Please initial:** ____

Updated: 9/16/2025

I authorize you to release, to my attorney(s) and/or my insurance carrier(s), and/or the referring and/or family doctor, and/or school personnel such medical information as they may require or request.
**Please initial:** ____

**AI:**
I acknowledge that Professional Hearing Services may use a secure, HIPAA-compliant artificial intelligence (AI) tool to assist in generating charts based on our visit. This tool is used solely to improve the accuracy and efficiency of documentation. My personal health information will be handled with strict confidentiality and in accordance with all applicable privacy laws.
**Please initial:** ____

**No Show/Same Day Reschedule Policy:**
As a courtesy to our patients, we make every effort to remind everyone of upcoming appointments through automated text reminders and phone calls. However, ultimately, it is the patient's responsibility to remember scheduled appointments. We require 24-hour cancellation or rescheduled notice prior to the scheduled appointment. If notice is not given 24 hours prior to the appointment time, a fee up to $50 may be charged. This fee also applies to patients who do not show on the day of the scheduled appointment.
**Please Initial**____

**PHI:**
Due to HIPAA regulations, please list any authorized person(s) with whom we may discuss your appointments, scheduling needs, diagnosis, insurance and/or payments or who may be allowed to pick up hearing aids and/or materials for you from our office.

Name of Authorized Person(s): Relationship to Patient: Phone Number:

______________________________________________

______________________________________________

______________________________________________

Patient Name: ________________________ Date of Birth: ________________________

Signature ________________________________Date:______________________________

***Responsible party signs if patient is a minor or is unable. Please provide Power of Attorney or guardianship paperwork if applicable.***

Updated: 9/16/2025