HIPAA Statement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Assignment of Benefits - Authorization and Release

I authorize the release of pertinent information necessary to process my medical claim. I hereby assign all insurance benefits to which I am entitled, including Medicare, private insurance and any other health plans to **SOUTHERN VERMONT AUDIOLOGY** for services rendered. The assignment will remain in effect until revoked by me in writing. I understand that if my insurance requires a referral, I am responsible for obtaining one prior to my appointment. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.
I also authorize **SOUTHERN VERMONT AUDIOLOGY** to release any and all medical information in the course of my treatment to the primary care physician provided. Also to: _____

Informed Consent Agreement

I understand that during my hearing evaluation, various earphones and earphone inserts will be placed over my ears and in my ear canals in order to deliver acoustic signals.

I understand that in order to make a custom ear mold or hearing aid, an impression of my ear will be taken. This will entail the placement of a foam block and silicon impression material into my ear canal. The ear impression process may cause discomfort and temporary hearing loss.

I understand that the audiologist may need to remove cerumen (ear wax) from my ear canals in order to achieve accurate test results. The process of cerumen removal may cause discomfort, bleeding, temporary hearing loss, infection, dizziness and tinnitus. At any point during cerumen removal, I may request the procedure be stopped. **By signing this form of consent, I am agreeing that I have been informed of the aforementioned risks and would like to continue with evaluation.**

Patient Name: _____Date:_____

Signature:_____ Relationship to Patient:_____