Denison Hearing

Doctor of Audiology Hearing Healthcare

Patient: _____ DOB:_____ Date: _____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the Notice of Privacy Practices for Denison Hearing, which describes how my medical information may be used and disclosed. Initials: _____

AUDIO RECORDING FOR AI-ASSISTED NOTES (OPTIONAL)

Denison Hearing may use a secure transcription service, bound by a written agreement to protect my health information, to prepare visit notes from an audio recording of my appointment. Saying no will not affect my care, and I may change my answer at any time.

☐ Yes, you may record my visits ☐ No, please do not record my visits Initials: _____

ASSIGNMENT OF INSURANCE BENEFITS

I authorize direct payment of medical benefits to Denison Hearing for services rendered, and authorize Denison Hearing to release medical information necessary to process insurance claims. I understand I am responsible for any amount my insurance does not pay. Initials: _____

INFORMED CONSENT FOR AUDIOLOGIC EVALUATION AND TREATMENT

I authorize Denison Hearing to perform audiologic testing, hearing evaluations, hearing aid fittings, and/or any related procedures deemed necessary. I understand the purpose, risks, and benefits of the services provided. I acknowledge that no guarantees have been made regarding the outcome of evaluation or treatment. Initials: _____

To request or send records, please complete the separate Authorization to Use or Disclose Health Information form.

Signature of patient or representative: _____ Date: _____

If signed by a representative, printed name and relationship: _____

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