Patient Consent & Acknowledgment

Ascent AUDIOLOGY & HEARING

Consent to Release Information

Authorization for Release of Protected Health Information to a Trusted Individual

_____ Initial

By initialing this paragraph, I authorize Tri-State Hearing Services, LLC dba Ascent Audiology & Hearing to communicate with the Trusted Individual(s) named below about my prognosis and treatment plans, diagnosis, test findings, reports and invoices related to my healthcare.

Physician Name: _____

Friend or Family Member

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Consent to Communicate electronically between Patient and Ascent Audiology & Hearing Staff

_____ Initial

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.

_____ Initial

I agree that I will NOT use email or text to communicate any urgent matters to the staff of Ascent Audiology & Hearing. I understand that email sent from Ascent Audiology & Hearing 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 communication sent between Ascent Audiology & Hearing and myself.*

Assignment of Benefits

_____ Initial

I am aware that by initialing this section, I am authorizing Ascent Audiology & Hearing to bill my insurance benefits to be paid directly to Ascent Audiology & Hearing 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 Ascent Audiology & Hearing by my insurance carrier(s) for services rendered by Ascent Audiology & Hearing.

Written Acknowledgment of Notice of Privacy Practices Offered:

_____ Initial

By initialing this paragraph, I acknowledge that I have been offered a copy of Ascent Audiology & Hearing Notice of Privacy Practices.

Signature: _____ Date: _____ / _____ / _____

***Ascent Audiology & Hearing is committed to keeping your email address confidential.**

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