A Plus Audiology and Hearing Aid Services

Patient Name:_____ Date of birth:_____

Social Security # (**Veterans only**): _____ Gender: _____

Address:_____City:_____State:_____Zip:_____

Email address: _____

Occupation: _____ Name of spouse (if applicable): _____

Primary phone #: _____ Secondary phone #: _____

Method of payment:_____

Parent's Name *(if patient is a minor)*:_____

Physician: _____

Referred by:_____Reason for referral: _____

CONSENT, PRIVACY AND RELEASE FORM

I consent to receive audiological services from The Moonflower Group, LLC, DBA **A Plus Audiology and Hearing Aid Services (A+ Audiology)**. This consent encompasses audiological procedures including, but not limited to, diagnostic testing, rehabilitative treatment, ear wax removal, and taking of ear mold impressions. I understand that this consent form will be valid and remain in effect as long as I receive audiological care from A+ Audiology.

Patient Signature_____ **Date** _____

Guardian/Power of Attorney Signature_____ **Date** _____

In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician and/or the provider, if any, who referred me here.

Patient/Guardian Signature_____ **Date** _____

I hereby authorize the release of any medical or other information necessary to process my insurance claim. I further authorize payment of medical benefits to A+ Audiology for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office. This is to serve as a long-term authorization card.

Patient/Guardian Signature_____ **Date** _____

I hereby expressly acknowledge that the A+ Audiology Notice of Patient Privacy Practice has been made available to me.

Patient/Guardian Signature_____ **Date** _____

Patient Authorization of Disclosure

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The patient may revoke or change this authorization at any time with a written request.

I wish to be contacted in the following manner (Check all that apply):

____Primary Telephone:

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

___Work Telephone:

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Do not call me at work

Written Communication

- ☐ O.K. to mail to my home address
- ☐ O.K. to fax to my home fax:
- ☐ O.K. to email:
- ☐ OTHER: _____

Would you like to receive information on promotional items?

☐ yes ☐ no Via: ☐ Email ☐ Mail ☐ Text

Please indicate any other parties or family members with which you would like us to be able to communicate health, insurance, and/or financial information relating to your hearing health care.

Name:_____Phone # _____

Relationship: _____

Name:_____Phone # _____

Relationship: _____

Name:_____Phone # _____

Relationship: _____

Name:_____Phone # _____

Relationship: _____

Name:_____Phone # _____

Relationship: _____

Patient/Guardian Signature_____ **Date** _____