PATIENT CONSENT AND ACKNOWLEDGEMENT

Rankin audiology & hearing

Authorization for Release of Protected Health Information to a Trusted Individual (Family, Friend, Physician etc.):

_____By initialing this paragraph, I authorize Rankin Audiology and Hearing LLC to communicate with the Trusted Individual(s) below about my prognosis and treatment plans, diagnosis, test findings, reports and invoices related to my healthcare.

Primary Care Physician:_____

Name:_____Relationship to Patient:_____

Name:_____Relationship to Patient:_____

Written Acknowledgement of Notice of Privacy Practices Offered:

_____By initialing this paragraph, I acknowledge that I have been offered a copy of Rankin Audiology and Hearing's notice of Privacy Practices.

Consent to communicate electronically between Patient and Rankin Audiology and Hearing Staff:

_____By initialing this paragraph, I agree to receive appointment reminders, office information; including but not limited to, location information, hours of operations, change of address, hardware & software update notifications, TeleHear communication and connectivity, marketing information and promotions, diagnostic information, or other information or forms via the internet, email, or text.

I agree that I will NOT use email or text to communicate any urgent matters to the staff of Rankin Audiology and Hearing. I understand that email sent for Rankin Audiology and 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 Rankin Audiology and Hearing. The office is committed to keeping your email address confidential.

Assignment of Benefits:

_____I am aware that by initialing this section I am authorizing Rankin Audiology and Hearing to bill my insurance benefits to be paid directly to Rankin Audiology and 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 Rankin Audiology and hearing by my insurance carrier(s) for services rendered.

Signature:_____Date:_____