HIPAA DISCLOSURE, RELEASE OF INFORMATION, CONSENTS, COMMUNICATION, PHOTO ID & INSURANCE

Please read and initial each policy statement, and sign at the bottom of the form.

PATIENT PRIVACY POLICY: I acknowledge that a copy of **Superior Audiology's** patient privacy policy was offered or given to me. Initials: _____

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize the release of information to my referring physician, as well as to my insurance company to process my medical claims.
Initials: _____

CONSENT: I authorize **Superior Audiology** to perform Diagnostic Hearing Evaluations and/or other services that is/are required for my appointment. Initials: _____

CONSENT TO BILL: I authorize **Superior Audiology** to submit all invoices to my insurance company, if I have health insurance. Otherwise, if I do not have health insurance, I authorize **Superior Audiology** to collect the balance owed, on the Date of Service.

- I understand that my insurance may not cover all billed charges. I understand that I am responsible for any part of the charges that are not covered by my insurance and that I will be billed directly for those services.
- If I do not have medical insurance, I understand that I am responsible for all charges incurred and that the balance is due on the Date of Service. Initials: _____

COMMUNICATION AGREEMENT: I understand that **Superior Audiology** will need to contact me in order to remind me of an appointment, give instructions or provide other information.
Initials: _____

PHOTO ID & INSURANCE: Due to new government regulations regarding insurance fraud and mistaken identity, we will be taking photo copies of the patients/parent or guardians driver's license or another form of photo ID, as well as all insurance cards. Initials: _____

My signature below acknowledges that I have read and agree to the above listed policies.

_____ _____
Patient/Parent or Guardian Signature Date