



CHAMPLAIN VALLEY AUDIOLOGY

A Hearing & Tinnitus Practice

Patient Information

Date _____

Patient Name _____ DOB _____

Mailing Address _____
Street City/State/Zip code

Please check all allowed means of communication:

- You may contact me at my **home** telephone number: _____
- You may contact me on my **mobile** telephone number: _____
- You may contact me on my **work** telephone number: _____
- You may send me an unencrypted **email, including test results** at: _____

Emergency Contact _____ **Phone #** _____

Relationship to Patient _____

Primary Care Physician _____

We know that you have a choice in hearing care. Why did you select our office for your visit today?

Consent for Release of Information

Name of Patient: _____ DOB: _____

(please initial all 3 boxes)

I HEREBY AUTHORIZE *Champlain Valley Audiology* to release any and all information contained in the medical record of the above listed patient to any third party payer for whom I may seek payment or reimbursement for expenses related to my office visit. I also authorize *Champlain Valley Audiology* to use Claims Connection to process such claims.

I HEREBY ASSIGN and set over all insurance benefits to which I am entitled and which are otherwise payable to me to *Champlain Valley Audiology*.

I HEREBY AUTHORIZE *Champlain Valley Audiology*, having treated me, to release information to other health care facilities or physicians involved in my care.

Please list authorized persons with whom we may discuss your Protected Health Information in addition to custodial parents and legal guardians:

1. _____
2. _____
3. _____
4. _____

Signature of Patient

Other Authorized Signature

Date

Relationship



Print Name of Client

Print Name of Personal Representative (if applicable)

Description of Personal Representative's Authority

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
(Notice of Privacy Practices Version Number 1.0, Dated June 18, 2008)

By signing below, I acknowledge that I have been provided a copy of this *Notice of Privacy Practices* and have therefore been advised of how certain health information about me may be used and disclosed by Champlain Valley Audiology and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information and genetic information.

Consent for Treatment, Payment and Health Care Operations

In providing service to you, we create and store health information that identifies you. We understand that this information about you and your health is personal, and we are committed to protecting the privacy of this information. We must obtain your written consent before we treat you, obtain payment or provide services at Champlain Valley Audiology. ***Please read carefully the information below before signing this form.***

Scope of Consent: By signing this consent form, you will permit Champlain Valley Audiology and its staff to use your protected health information for treatment, payment, and normal business operations. You also permit our staff to share your information with other persons or organizations outside this practice that perform payment activities and business operations jointly with the practice.

Notice of Privacy Practices: We have a *Notice of Privacy Practices* that describes these uses and disclosures in detail and we encourage you to read it. We want you to know, however, that the *Notice of Privacy Practices* is subject to change. If it is changed, you may obtain a copy of the revised notice by asking for a copy at your next visit or by calling our office.

Restricting Use and Disclosure: You have the right to ask us to restrict the uses or disclosures of your protected health information. Champlain Valley Audiology is not required to agree to this restriction, but if it does, it will be bound by its agreement unless the information is needed to provide you with emergency treatment or comply with the law.

Revoking consent: You have the right to revoke this consent at any time, except to the extent that Champlain Valley Audiology has provided you with treatment, the practice will be permitted to use or disclose your protected health information to bill for that treatment. To revoke this consent, please contact our office.

I have read this consent and understand it. I consent to the use and disclosure of my health information for the purposes of treatment, payment, and health care operations.

I also consent to be contacted via phone and email (if email address has been provided).

Signature of Client or Personal Representative

Date



Office Financial Policy

Payment is due at the time of service. All copays and co-Insurances must be paid at the time of service, failure to do so will result in the rescheduling of your appointment. We accept cash, personal checks, Visa, Master Card, Discover, and American Express.

•We do also offer financing through Care Credit, please see our office manager for more information.

Insurance Verification is not a guarantee of coverage. Your insurance policy is a contract between you and your insurance company. At Champlain Valley Audiology, we are happy to verify your benefits prior to your appointment and require all insurance information to be given to office staff at the time of scheduling. We will do our best to maximize all benefits you are entitled to.

Cancellation Policy and Continuation of Care: Maintaining a relationship with our patients is our top priority and consistency of care is key to maintaining proper hearing health. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. We request and appreciate a notification at least **24 hours** in advance to cancel an appointment. We reserve the right to dismiss any patient from our practice who misses or cancels, without 24 hour notice, three or more consecutive appointments. Appointment changes must be made directly through our office, a message may be left on the machine when the office is not open.

I have been given the opportunity to ask questions regarding this policy. I have read and understand the financial policy.

Signature: _____

Date: _____

Champlain Valley Audiology

Medication Log

Name: _____ DOB: _____

Please be sure to complete all four columns

Medication Names: Includes prescription, over The counter, vitamins & Herbal supplements	Dosage	Frequency	How is it taken (orally, Injection, patch, Inhaler, etc.

In order to stay compliant with new insurance regulations, we are required to ask you for a list of your prescriptions and over the counter medications, herbal supplements and vitamins.