Quiet Corner Hearing Aids

Last Name: _____ First Name: _____

Mailing Address:

City: _____ State: _____ Zip Code: _____

SS #: _____ Date of Birth: _____ Email: _____

Language: _____ Ethnicity: _____ Race: _____ Sex: _____

Marital Status: _____ Occupation: _____ ☐ Home Phone: _____

Please check the preferred number. ☐ Cell Phone: _____ Are we able to text you? ☐ Yes / ☐ No

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Primary Insurance Card Holder:

Self: _____ Last Name: _____ First Name: _____ Date of Birth: _____

Phone: _____ Relationship: _____ Address: _____

Guarantor Information (If Minor):

Last Name: _____ First Name: _____

Address: _____ SS #: _____ City: _____

State: _____ Zip Code: _____ Date of Birth: _____

**Is this appointment workers' comp or accident-related? ☐ YES or ☐ NO

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN/TO RELEASE INFORMATION: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PHYSICIAN OF THE SURGICAL OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR THEIR SERVICES AS DESCRIBED, REALIZING I AM RESPONSIBLE FOR PAYING NON-COVERED SERVICES. I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF TREATMENT NECESSARY TO PROCESS MY INSURANCE CLAIMS.

Patient Signature: _____ (Parent if Minor) Date: _____

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CONFIDENTIAL COMMUNICATION REQUEST

Patient Name: _____

Patient Date of Birth: _____

As required by the Health Insurance Portability and Accountability Act of 1996, you have a right to request that communications concerning your personal health information be made through confidential channels.

****Would you like to give our office permission to speak with anyone other than yourself (such as a family member, friend or facility) regarding your medical information?** ☐ YES or ☐ NO

IF YES, PLEASE LIST BELOW:

Name: _____

Relationship: _____

Telephone #: _____

Patient Signature: _____

Print Name: _____

Today's Date: _____

If not signed by the patient, please indicate the relationship to the patient: _____

Turn Over for Page 3

Upper Level, 145 Pomfret Street, Putnam, CT 06260
P: (860) 481-3063 • ent-docs.com

Quiet Corner Hearing Aids

REVISED/UPDATED

Notice of Privacy Practices Acknowledgement

The full notice is available upon request at the front desk.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and physician certifications.

I understand that I may get the complete Notice of Information Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Information Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Information Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Revised Notice:

Release authorizations: Certain disclosures and uses of protected information will require my authorization.
They include: 1. Psychotherapy notes. (The notes of a mental health professional that are separate from the record), 2. Any information the office will use for marketing and 3. Any sale of the office's patient information.

Restricting information releases: A patient who pays for a service in full and out of pocket can request that our office not disclose any information about that service to an insurance company. This request must be in writing specifically requesting what information the patient wants to restrict and what insurance company is not to receive it.

Breach notification: This office will notify me in writing if or when a breach of my protected information occurs.

Patient Name: _____

Patient Signature: _____

Relationship to Patient: _____

Date: _____

NO-SHOW POLICY

A $100.00 fee is charged for no-show consultation appointments.

A $100.00 fee is charged for no-show fitting appointments.

A $35.00 fee is charged for no-show follow-up appointments.

Our office commits to making every effort to confirm upcoming appointments a minimum of one day in advance. We personally attempt to call all appointments to confirm. We respectfully ask for a 24-hour notice when canceling a scheduled appointment.

Repeated no-shows may result in being discharged from the practice.

Patient Signature: _____ Date: _____

Printed Name: _____

Relationship to the patient if signing for the patient: _____

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