CONSENT, PRIVACY, AND RELEASE FORM

I consent to receive audiological services from Audiology and Hearing Aid Services. This consent encompasses audiological procedures including, but not limited to, diagnostic testing, rehabilitative treatment, ear wax removal, and taking ear mold impressions. I understand that this consent will be valid and remain in effect as long as I receive audiological care from Audiology and Hearing Aid Services.

Patient Signature _____ Date _____

Guardian/Power of Attorney Signature _____ Date _____

I hereby authorize the release of any medical or other information necessary to process my insurance claim, if applicable. I further authorize payment of medical benefits to Audiology and Hearing Aid Services for the services described on the insurance form. This authorization is to apply to all occasions of service until 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 Signature _____ Date _____

Guardian/Power of Attorney Signature _____ Date _____

I hereby expressly acknowledge that the Audiology and Hearing Aid Services Notice of Patient Privacy Practice has been made available to me.

Patient Signature _____ Date _____

Guardian/Power of Attorney Signature _____ Date _____

I hereby authorize Audiology and Hearing Aid Services to use or disclose my name, mailing address, or email address for the purpose of sending me materials that market or promote hearing health care products, services or therapies, including hearing aids, for which XYZ Business may receive direct or indirect payment from the third-party hearing health care company whose products or services are being promoted in such communications

Patient Signature _____ Date _____

Guardian/Power of Attorney Signature _____ Date _____