Patient agreement

Please read carefully and sign below:

- ☐ The FDA has determined that it is in my best health interest to have a medical evaluation by a licensed physician (preferably a physician who specialized in diseases of the ear) before purchasing hearing instruments. I have been advised by my hearing healthcare professional and/or his or her agents about this determination and hereby waive this requirement.
- ☐ I give permission to my hearing healthcare professional to release information—verbal and written, contained in my medical records and other documents—to my insurance company, rehab nurse, case manager, attorney, employer, healthcare providers, assignees and/or beneficiaries and all other relevant persons. Information that does not identify me as the patient may be used for quality purposes.
- ☐ I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy for this office.
- ☐ I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services rendered or purchases made.
- ☐ I have read all the information on this sheet, have provided the requested information, certify this information is true and correct to the best of my knowledge, and hereby give my hearing healthcare professional permission to treat my condition.

Signature: ______________________ Date: ______________

Signature: ______________________ Date: ______________
SIGNATURE OF PARENT OR GUARDIAN IF PATIENT IS A MINOR

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