ADVANCED HEARING, LLC.

PRIVACY POLICY ACKNOWLEDGEMENT STATEMENT

I hereby acknowledge that I have been made aware that Advanced Hearing has a privacy policy in place in accordance with the Health Insurance Portability and Accountability ACT of 1996 (HIPAA).

As a patient of Advanced Hearing, I understand and acknowledge the following:

1. Advanced Hearing has a privacy policy in effect in their office.
2. Advanced Hearing has made this policy available to me for review by placing a complete version in a binder that resides in the waiting room, or by placing a poster of this policy in the waiting room or similar common area with patient access.
3. Advanced Hearing has made me aware that as a patient, I am entitled to a copy of this privacy policy if I desire a copy for my personal file.

Upon review of the above statements, please sign the bottom, acknowledging that you have been advised of the privacy policy implemented by Advanced Hearing and have read and understood the acknowledgment form.
If you desire a copy of the privacy policy, please request one at this time.

☐ No, I do not want a copy, but acknowledge the privacy policy exists.

☐ Yes, I do want a copy of the privacy policy.

Patient Signature (Guardian, if patient is a minor) _____ (Date) _____

PATIENT AGREEMENT FOR COMMUNICATION

I understand that as part of my health care, Advanced Hearing will need to contact me in order to remind me of an appointment, provide test results, give instructions, or provide other information.

I authorize Advanced Hearing to contact me in the following ways (check those which you authorize):

☐ Home phone ☐ Voicemail OK

☐ Work phone ☐ Voicemail OK

☐ Cell phone ☐ Voicemail OK ☐ Text OK

☐ Fax

☐ E-Mail E-mail Address: _____

Advanced Hearing does not use secure server for e-mail communication. Because a secure server is required by law for e-mail communication with patients, Advanced Hearing does not endorse the use of e-mail communication with patients.

I understand that Advanced Hearing will use the minimum necessary information needed when communicating with me indirectly. I understand that I may revoke or modify this agreement at any time. Any revocation or change will not apply to past communications.

I further authorize Advanced Hearing to discuss matters related to my condition or care with the following:

_____ _____

Patient's representative name Relationship to patient

_____ _____

Signature of patient (Guardian, if patient is a minor) Date