3290 North Ridge Road, Suite 125
Ellicott City, MD 21043
Phone: #410.696.2890 Fax: #410.696.2886

Date: ____/____/____

Patient Information:

First Name: ________________________ Middle Initial: _____ Last Name: ____________________________

Preferred name: _____________________ Gender: ___Male ___Female

Date of Birth: ____ ____/____ ____/____ ____ ____ ____ Employer: ____________________________________

Address: ____

City: _____________________________ State: __________ Zip code: ____ ____ ____ ____ ____

Marital Status: Single / Married / Widowed / Other Employment: Full time/ Part time/ Self/ Unemployed/ Retired

Emergency Contact: ____________________________ Phone: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Power of Attorney (POA): ________________________ Phone: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Primary Care Doctor: ___________________________ Phone: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Referring Doctor: ______________________________ Phone: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

How did you hear about us? ____

Person Financially Responsible: **(if other than patient)**

Name: ____ Relationship to patient: ______________________

Address: ____

City: _____________________________ State: __________ Zip code: ____ ____ ____ ____ ____

Home Phone: (___ ___ ___) ___ ___ ___- ___ ___ ___ ___ Other Phone: (___ ___ ___) ___ ___ ___- ___ ___ ___ ___

Primary Insurance Information: **(please enter the policy holders information)**

Insurance Company: ______________________________ Policy/ID Number: _____________________________

Policy Holders Name: ______________________________ Policy Holders Date of Birth: _____/_____/________

Relationship to patient: ______________________ Employer: __________________________________

Secondary Insurance Information: **(please enter the policy holders information)**

Insurance Company: ______________________________ Policy/ID Number: ______________________________

Policy Holders Name: ____________________________ Policy Holders Date of Birth: _____/_____ /________

Relationship to patient: ______________________ Employer: ___________________________________

I, the undersigned, hereby certify that the information on this form is current and accurate as of the below date. I understand that this information will not be sold or given to any third party in exchange for monetary compensation. By signing below, I consent to receiving marketing updates (via mail, email or phone) including but not limited to: clinic service notifications, health notifications, marketing or promotional events such as educational seminars, free battery giveaways, etc.), and any other service or product updates that could benefit me or help improve my health. In some instances, the cost of a mailing or other communication may be paid by a hearing aid company. I understand that I can revoke this authorization at any time.

Patient or Patient Representative's Signature:______________________________________ Date: _____________

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The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual also has the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending the correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Phone: ________________________ OK to leave message with detailed information

Cell Phone:___________________________ OK to leave message with detailed information

OK to communicate via text message

Work Phone:_______________________ OK to leave message with detailed information

Email: ____________________________

Authorization for Email Communications: I hereby consent to have my audiologist or members of his/her staff communicate to me via email where appropriate regarding my medical care and treatment (test results, prescriptions, appointments, billing, office updates, etc). _______ Initials of Patient or Parent/Legal Guardian's Signature

Telephone Consumer Protection Act (TCPA): You agree, in order for us to service your account or to collect monies you may owe, Clarity Audiology, and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages at the phone number you provide to use.
I/We have read this disclosure and agree that Clarity Audiology, its employees and/or agents may contact me/us as described above._______ Initials of Patient or Parent/Legal Guardian

Person's authorized to discuss my Personal Health Information (check all that apply):
I further authorize Clarity Audiology, to discuss my protected health information (PHI) with the following persons or organizations. Please provide name and relationship (there is no limit to the number of individuals that may be authorized to receive my PHI).

Spouse___________________________ Other______________________ Relationship_______________

Son/Daughter______________________ Other______________________ Relationship_______________

Parent(s) __________________________ Other______________________ Relationship_______________

Notice of Privacy Policy Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act of 1996, I have certain rights to privacy regarding my protected health information which can and will be used to:

- *Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.*
- *Obtain payment from third-party payers*
- *Conduct normal healthcare operations such as quality assessments and physician certifications.*

I have received, read and understand your Notice of Privacy Policy containing a more complete description of uses and disclosures of my health information. I understand that this organization has the right to change it Notice of Privacy Policy from time to time and that I may contact this organization at any time at the address above to obtain a copy of the Notice of Privacy Policy. 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 by such restrictions.

Print Patient's Name:__________________________________

Patient or Parent/Legal Guardian's Signature:____ Date: ______________