Clarity Audiology & Hearing Solutions, LLC

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: ____ ____/____ ____/____ ____ ____ ____ Email address: _____

Address: _____

City: _____ State: _____ Zip code: ____ ____ ____ ____ ____

Home Phone: (___ ___ ___) ___ ___ ___- ___ ___ ___ ___ Cell Phone: (___ ___ ___) ___ ___ ___- ___ ___ ___ ___

Work Phone: (___ ___ ___) ___ ___ ___- ___ ___ ___ ___ Employer: _____

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 direct 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 could benefit me or help to improve my health. In some instances, the cost of a mailing or other communication may be paid for by a hearing aid company. I understand that I can revoke this authorization at any time.

_____ _____

Signature of patient or personal representative Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

1. I authorize the Practice to release PHI about me to the family members or other individuals listed below, this information may be oral or written. I authorize my PHI to be disclosed only to the following identified individuals (*there is no limit to the number of individuals that may be authorized to receive my PHI*):

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

2. I also request that the following limitations be placed on the disclosure of my PHI to my family members or other identified above (*fill out only if you wish to limit some disclosures of PHI to the individuals listed above*):

_____

_____

_____

3. I understand that once PHI is disclosed to the individuals listed above, federal privacy protections may no longer apply to those disclosures and the Practice has no control over the use or re-disclosure of the information by my family members or other individuals who received my PHI.

_____ _____

Signature of patient or personal representative Date

AUTHORIZATION FOR EMAIL COMMUNICATIONS

I hereby consent to have my audiologist or members of his/her staff communicate with me via email, or have my audiologist communicate with his/her staff or other health professionals, where appropriate, communicate with me via e-mail regarding the following aspects of my medical care and treatment [test results, prescriptions, appointments, billing, etc.]

_____ _____

Signature of patient or personal representative Date

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I received a copy of Clarity Audiology & Hearing Solutions' Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area and that any revised Notice of Privacy Practices will be made available.

_____ _____

Signature of patient or personal representative Date