Clarity Audiology & Hearing Solutions, LLC

Ellicott City:
3290 North Ridge Rd., Suite 125
Ellicott City, MD 2104

Eldersburg:
1380 Progress Way, Suite 109
Eldersburg, MD 21784

Phone: 410.696.2890
Fax: 410.696.2886
www.clarityhearing.com

Date: ___/____/____

Patient Information:

First Name: _____ Middle Initial: _____ Last Name: _____

Preferred name: _____ Gender: __Male __Female Date of Birth:___ ___/___ ___/___ ___ ___ ___

Address: _____

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

Employer: _____ Occupation: _____

Please indicate PRIMARY phone type: CELL / HOME / WORK

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

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

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

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

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

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

Responsible Party/POA Name: _____ Phone: _____

How did you hear about us? _____

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

Name: _____ Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip code: _____ Phone: (___ ___ ___) ___ ___ ___- ___ ___ ___ ___

Primary Insurance Information: **(please enter the policy holder's 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 holder's information)**

Insurance Company: _____ Policy/ID Number: _____

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

Relationship to patient: _____ Employer: _____

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HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)
Protected Health Information (PHI) Authorizations &
Notice of Privacy Practices Acknowledgement

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. By signing below, I agree to be contacted in the following manners noted below.

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

PRIMARY #: _____ Type: Cell / Home / Work ☐ OK to leave message with detailed information

Phone #2: _____ Type: Cell / Home / Work ☐ OK to leave message with detailed information

Phone #3: _____ Type: Cell / Home / Work ☐ OK to leave message with detailed information

Email: _____

Persons authorized to discuss my Protected Health Information:
By signing below, I authorize Clarity Audiology & Hearing Solutions, LLC 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).

Name_____ Relationship_____ Phone: _____

Name_____ Relationship_____ Phone: _____

Name_____ Relationship_____ Phone: _____

EMERGENCY CONTACT: /PHONE:

ACKNOWLEDGEMENT 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, the website and that any revised Notice of Privacy Practices will be made available.

_____ _____
Printed name of patient or personal representative Date

_____ _____
Signature of patient or personal representative Date