BETHESDA AUDIOLOGY CENTER
(301) 656-1933

8218 Wisconsin Ave., Ste. 106
Bethesda, MD 20814

PATIENT ACKNOWLEDGEMENT AND CONSENT

ACKNOWLEDGEMENT OF NOTIFICATION

The educational material entitled "Notice of Privacy Practices" provides information about how BETHESDA AUDIOLOGY CENTER may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, we will post the changes in our office.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment or health care operations. We are not required to agree to your restrictions; but if we do, we are bound by our agreement with you.

We believe that your health information is private to you. We make every effort to protect your information from unnecessary disclosure, including the following procedures: we educate our staff to keep information confidential; we discard protected information in appropriate containers or shred it; we require your written authorization prior to disclosing information to sources not identified in our privacy practice; you may revoke your written authorization at any time by sending us a written request.

By signing below, you acknowledge that our Privacy Policy has been made available to you.

Signature _____ Date _____

Parent Signature if Minor _____ Date _____

CONSENT FOR USE AND DISCLOSURE OF INFORMATION

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare or any other Insurance Carrier benefits be made on my behalf to BETHESDA AUDIOLOGY CENTER for any services and/or products furnished to me by that health care specialist or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services and/or products. I agree to provide all referrals as required by my Insurance Carriers. All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier Agreements. All non-covered services and/or products must be paid for at the time the service is rendered or the product is dispensed.

Signature _____ Date _____

Parent Signature if Minor _____ Date _____

Printed Full Name _____