acoustic hearing center

Acoustic Hearing Center
1163 Willis Avenue,
Albertson, NY 11507-1203
(516) 484-0811

PATIENT INFORMATION FORM

Patient Name (Last) ______________ (First) _________________(Middle Initial) _____

Address:____

Telephone # Home:______________ Cell:________________

E-Mail:__________________________ DOB:__________________

Physician Name, Address & Telephone #:

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Emergency Contact: __________________ Phone Number: _____________________

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1. Are you a previous Acoustic Hearing Center Patient ☐ No ☐ Yes
If yes, which office:_________________________

2. How did you hear about the Acoustic Hearing Center? ______________________

3. Is this visit covered by a Health Insurance Plan? ☐ No ☐ Yes

4. Is this visit covered by any other payers? ☐ No ☐ Yes
Example: Worker Compensation, a secondary health insurance plan, a family member's insurance plan, your Employer etc.)

CONSENT TO USE AND DISCLOSURE OF HEALTH INSURANCE

- By signing this form, you are granting consent to Acoustic Hearing Center to use and disclose your protected health information for purposes of treatment, payment & health care operations. Our Notice of Privacy Policy Practices provides more data information about how we may use and disclose this protected health information.

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- Although Acoustic Hearing Center does not sell or release patient information to third parties, Acoustic Hearing Center gives you the opportunity to receive promotions or information about our products & services. If you prefer **NOT** to receive communications about products & services, please check here to set you contact preference to "no contact" ☐

- You may choose another person to help with your clinical visits or speak to the Acoustic Hearing Center by phone. This person requires you to give written permission to discuss your treatment and your private health information with our staff. If you choose to give the permission to someone, please designate that individual and your relationship to him/her. If no one, please leave blank
(full name) ____________________ (relationship)__________________

- You have a legal right to review our Notice of Privacy Practices before you sign this consent & we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may view changes in information by accessing our website at: www.theacoustichearingcenter.com/privacy-policy/ or by requesting the updated notice from our customer service in clinics in a non-electronic format.

-You have the right to request that we restrict how we use and disclose your protected health information for the purpose of marketing, treatment, payment or healthcare operations. Depending on the nature of your request, we are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

-In order to provide you with the best customer service & patient experience, your appointment may be monitored for quality & training purposes. If you do not wish to have you appointment monitored, please check this box ☐

Signature: __________________________ **Date:**____________________