Welcome to

Corvallis Hearing Center

Date: _____/_____/_____

Full Legal Name: _____

Preferred Name: _____

Address: _____

City: _____ State: _____ Zip code:_____

Birth date:_____/_____/_____

Sex: ☐ Male ☐ Female

Cell Phone#: _____ ☐ Preferred Text? ☐ Y ☐ N

Landline#: _____ ☐ Preferred

E-Mail: _____ ☐ Preferred

How did you hear about us/Referred By? _____

Primary Care Physician: _____

Please bring your Medicare card and any other insurance cards along with your identification card up to the receptionist to make copies.

VETERAN PATIENTS ONLY:

FULL SOCIAL SECURITY #: __ __ __ - __ __ -__ __ __ __

Patient Financial Responsibility Form

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes Comprehensive Audiological Testing, Hearing Aids, Cerumen Removal and Hearing Aid Services by the doctor or staff. These different procedures are subject to different coverage by your insurance company. Some of these charges may be covered by your insurance, and some may not.

Our office will contact your insurance company to determine if prior authorization is required for your scheduled procedure. If authorization is required, our office will complete the prior authorization process.

While we confirm your benefits as a courtesy to you, confirmation of benefits **is not a guarantee of payment** and that you are responsible for any unpaid balance that your insurance company deems your responsibility or that is "not billable" or "not allowed".

Certain procedures and charges that are deemed "not billable" or "not allowed" by your insurance company will be billed directly to you at the time of service. It will be your responsibility to pay the balance at the time of service. Our office does not bill your insurance company for procedures that are deemed "not billable" or "not allowed".

It is strongly recommended that patients check with their insurance plan to make sure that the provider is contracted with your insurance plan, and that the procedure and hearing aids are billable and allowable.

_____ **Initial**

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive, and I agree to make payment in full.

_____ **Initial**

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

_____ **Initial**

If I am a Medicare patient, I understand that I need to provide the office both my Medicare Health Insurance card and my ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

Please sign below to acknowledge that you have read this information and accept responsibility for all services rendered by Ron Leavitt, Au.D., Corvallis Hearing Center, and Hearing Assistance Technology, Inc., regardless of acceptance or denial by your insurance company. I acknowledge that payment is due when services are rendered or when my bill is received.

Patient Name Printed: _____

Patient Signature_____ Date: _____

Corvallis Hearing Center/Hearing Assistance Technology, Inc.
975 NW Spruce Ave, Suite 102, Corvallis, OR 97330
(541) 754-1377 (voice) (541) 754-9192 (fax)

Corvallis Hearing Center / Hearing Assistance Technology, Inc.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 11/01/2009, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to bill you, your insurance or other responsible party for payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. **Signing this privacy policy DOES NOT give us authorization to disclose your information to anyone for any purpose. If you want us to disclose your information to another person or entity you will need to sign an additional document called a Medical Release Form.**

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

PATIENT RIGHTS

Access: *You have the right to look at or receive copies of your health information. You must make a request in writing to obtain access to your health information.*

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **You must make your request in writing.** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us at:

Corvallis Hearing Center/Hearing Assistance Technology, Inc.
975 NW Spruce Ave, Suite 102, Corvallis, OR 97330
Voice: 541-754-1377, FAX: 541-754-9192

You also may submit a written complaint to the U.S. Department of Health and Human Services:

State of Oregon Department of Human Services, Governor's Advocacy Office
500 Summer St. NE, E17 Salem, Oregon 97301-1097
Phone: 800-442-5238 FAX: 503-378-6532 E-mail: GAOinfo@state.or.us

By signing below, I agree that I have reviewed and understand the information above, and that *I have received a copy of the Notice of Privacy Practices.*

Patient Signature_____ **Date:**_____

-OR-

Patient Representative Printed: _____ **Date:**_____

Patient Representative Signed: _____ **Date:**_____

Description of Patient Representative's authority:_____

---- File Copy ----

Revised: February 2022 Hearing Assistance Technology, Inc.