PIF HIPAA FORM

PATIENT NAME: _____
Last First Initial

ADDRESS: _____
Street City, State, Zip Code

PHONE NUMBER: _____ _____ _____
Cell Home Work

E-MAIL: _____ DATE OF BIRTH: _____

RESPONSIBLE PARTY: _____ _____ _____
Name Relationship Date Of Birth

PRIMARY PHYSICIAN NAME: _____

PRIMARY PHYSICIAN ADDRESS: _____

PHYSICIAN TELEPHONE: _____ FAX: _____

EMERGENCY CONTACT: _____ _____ _____
Name Relationship Phone

1. Are you a previous HearUSA patient? ☐ Yes ☐ No
   If yes, which office? _____
2. How did you hear about HearUSA? _____
3. Is this visit covered by a Health Insurance Plan? ☐ Yes ☐ No
   If yes, please present your member identification card and/or referral if applicable.
4. Is this visit covered by any other payors? ☐ Yes ☐ No
5. (Example: Worker Compensation, a secondary health insurance plan, a family member's insurance plan, your Employer, etc.) If yes, please present your member identification card and/or referral, if applicable.

CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, I am granting consent to HearUSA (the "Provider") to use and disclose my protected health information for the purpose of treatment, payment, and health care operations. The Notice of Privacy Practices provides more detailed information about how the provider may use and disclose my protected health information.

Although the provider does not sell patient information to third parties, by signing below, unless you opt out by checking the box below, you expressly consent to receiving calls, including auto-dialed and pre-recorded message calls, emails, marketing mail, and text messages from HearUSA and its affiliates and marketing partners, agents and others calling on HearUSA's behalf, at any telephone number that you have provided or may provide in the future (including cellular telephone numbers). Message and data rates may apply.

I opt out of receiving such marketing messages and calls ☐

I may choose another person to help with my clinical visits or speak to the provider on my behalf. This person requires my written permission to discuss my treatment and private health information. I choose to designate the individual below with this access. If no one, please leave this blank.

_____ (full name), _____ (relationship).

I have the legal right to review the provider's Notice of Privacy Practices before this consent is signed, and I've been encouraged to read it in full at https://www.hearusa.com/about-us/hipaa-policy/. The Notice of Privacy Practices is subject to change and will be updated accordingly. I have the right to request this notice in a non-electronic form.

I have the right to request that the provider restricts how they use and disclose my protected health information for the purposes of marketing, treatment, payment, or health care operations. The provider may not be required by law to grant my request, depending on the nature of the request. However, if the provider decides to grant my request, the provider is bound by our agreement. I have the right to revoke this consent in writing, except to the extent we already have used or disclosed my protected health information in reliance on my consent.

In order to provide me with the best customer service and patient experience, the appointment may be monitored or recorded for quality, training, and medical records documentation purposes. If I do not wish to have my appointment monitored or recorded, I will check this box ☐

_____ _____
Signature Date