Worth Hearing Center
Because Life is Worth Hearing

Patient Name: _____ Date of Birth: _____

HIPAA Acknowledgement

I understand that a copy of the Privacy Policy for this office is available to me upon request. The Notice provides information about how we may use and disclose the medical information that we maintain about you. You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed below. Please understand that revocation of this consent will not affect any action we take in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent. An electronic format of this Privacy Practice is available upon request by contacting the person below. Worth Hearing Center will NEVER sell your information for any purpose. By signing below, I authorize Worth Hearing Center to send me educational and/or marketing information on the products and services offered by Worth Hearing Center. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

Consent of Release for Protected Health Information (PHI)

I give permission to Worth Hearing Center to release information, verbal and written (contained in my medical record and other related information), to myself (parent/guardian), insurance company, related healthcare providers, case manager, rehab nurse, my attorney, employer, assignees and/or beneficiaries, and all other related persons.

I hereby give the following people permission to receive information from this office on my behalf:

(This is usually a spouse, partner, family member, close friend, guardian, etc.)

Name of Person: _____Relationship to me: _____ Phone: _____

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I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Worth Hearing Center and that this authorization is in effect until written notice of a revocation is received. This consent will expire 10 years from the date below, unless I provide a request with a different date.

Signature : _____ Date: _____

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Contact Person: Adrea Oyler
Address: 7520 Montgomery Blvd. NE, Ste E-15
Albuquerque NM, 87109
Phone: 505-872-4327
Email: aoyler@worthhearing.com

PLEASE FILL OUT BOTH SIDES

Financial Policy

Worth Hearing Center is committed to providing you with high quality audiological care in the most cost effective manner possible. In order to accomplish this, we depend upon your prompt payment for the services we provide.

Co-pays, when applicable, must be paid at the time of the appointment. If your insurance policy includes a co-insurance, the patient responsibility percentage must be collected at the time of the appointment.

If your insurance does not cover the services needed or you opt out of billing your insurance, an in-office discounted price will be offered to you and must be paid in full at the time of the appointment. If you choose to have Worth Hearing Center bill your insurance, the discounted rate no longer applies.

Insurance Cards must be presented at every visit. Correct and current insurance information is required for prompt and proper payment of claims.

Patients are responsible for checking their benefits and eligibility prior to the appointment. Patients will be liable for all non-covered services. A prior-authorization is not a guarantee that services will be covered.

Payment (full or partial) of outstanding invoices is required before subsequent appointments can be scheduled.

Patient Signature _____ Date _____