AudioLife Hearing Center

9724 Kingston Pike, Suite 205 Knoxville, TN 37922-3347
(865) 694-9870 Fax: (865) 694-9871

Patient Information Disclosure: I hereby give consent for AudioLife (Evans Innovations, Inc) to disclose/discuss and provide copies of the patient's private and protected health information to the following individuals. This request will remain in effect until revoked by me in writing.

Name/Phone/Relation: ____

Name/Phone/Relation: ____

Name/Phone/Relation: ____

1. I am the parent/legal guardian authorized to act on the patient's behalf. I hereby authorize audiological services to be provided to the patient by the Audiologists and staff of AudioLife (Evans Innovations, Inc) as necessary.

2. I hereby request access to my health information as authorized under HIPPA Privacy Rule, as provided in AudioLife's Privacy Notice. I am requesting that a copy of my hearing evaluation be provided to me.

3. I agree to be contacted by AudioLife (Evans Innovations, Inc) via phone (home/work/cell), mail (home), and/or email. I also grant AudioLife permission to leave a message regarding appointments, discussions, treatment plans, services rendered, insurance, etc. by AudioLife (Evans Innovations, Inc) at any of the phone numbers, addresses, and emails listed on the patient intake form.

4. Notice of Privacy Practices: I acknowledge receiving upon request, a copy of the providers' Notice of Privacy Practices (NPP). I understand the providers reserve the right to change the privacy practices that are described in the NPP. I understand that a copy of any Revised Notice will be provided to me or made available in the office. I consent to the providers' use of protected health information as described in the notice for treatment, payment, or health care operations. I understand that I must provide a separate authorization before any disclosers may be made.

5. Referral: I understand that if the patient's insurance requires a referral from the patient's primary care physician, the referral must be obtained prior to the visit to ensure the patient's maximum benefit from the insurance plan and is the responsibility of the patient or guardian. I further understand if the referral is not in place, I agree to taking full responsibility for payment due for services rendered by AudioLife (Evans Innovations, Inc).

6. Assumption of Responsibility: I understand and agree that in consideration of services to be rendered, I obligate myself and assume financial responsibility, and agree to pay upon demand to AudioLife (Evans Innovations, Inc.) all charges for such services and incidentals incurred (co-pays, deductibles, office visits, etc.). I understand and acknowledge that should the account be referred for collection, I shall pay all collection costs to the collection agency, court costs and legal fees and may affect my credit.

7. I understand that all services may not be covered by the patient's insurance plan. I understand that I am responsible to pay for all services rendered. Although insurance may be filed on the patient's behalf, I understand that all bills are payable upon receipt and that I, not the insurance company, am responsible for the payment of all services, products, etc.

8. I hereby authorize AudioLife (Evans Innovations, Inc) to release information to referring physicians, insurance companies, government agencies, etc. as necessary, for AudioLife to obtain payment for services rendered.

9. I authorize and request payment to be made directly to AudioLife (Evans Innovations, Inc) for insurance benefits payable for services provided by AudioLife. This authorization expressly includes benefits that are provided by TennCare and/or any other public or private insurance plan.

10. Arriving 15 minutes late or more for a scheduled appointment may result in your appointment needing to be rescheduled. If you need to reschedule or cancel an appointment, please call our office at least 24 hours prior to the scheduled appointment. Otherwise, it will be marked as a "no-show". After 3 no-show appointments, the patient may be dismissed from our practice at our discretion.

Patient' Name: ____

Patient/Parent/Guardian Signature: ______________________________ Date: ______________