ALLIED HEARING
Always Hear for You

2023 Patient Information/HIPAA

Allied Hearing
1290 E Broomfield St
Mount Pleasant, MI 48858
Phone: (989) 773-1209
Fax: (989) 773-4267
www.alliedhearing.com

Date:	Patient Name:		
DOB:	Sex:	Marital Status:	Spouse or Partner Name:
Phone #1 (Home / Work / Cell):		Phone #2 (Home / Work / Cell):	
Phone #3 (Home / Work / Cell):		Alternate Phone #:	
Email Address:			
Mailing Address:			
Secondary/Winter Address (Street/City/State/Zip):			
Emergency Contact:		Phone #:	
Relationship to Patient:			
Primary Care Physician:		Phone #:	
How did you hear about us?		Referred By:	
Occupation:		(If retired, prior occupation):	

HIPAA & Treatment Consent Form

__ I give Allied Hearing my consent to use or release my information, verbal and written (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes. I acknowledge that I received and reviewed the Health Insurance Portability and Accountability Act (HIPAA) policy of this office. I consent to receive audiological services from Allied Hearing. This consent compasses audiological procedures including, but not limited to, diagnostic testing, rehabilitative treatment, ear wax removal, and taking ear mold impressions. I understand that this consent form will be valid and remain in effect, as long as, I receive audiological care from Allied Hearing. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered. I have read all the information on this sheet, completed the above answers, certify his information is true and correct to the best of my knowledge, and hereby give Allied Hearing permission to treat my concerns. Appointments may be monitored for training and quality assurance purposes.

__ I request payment of authorized insurance benefits, including Medicare, to be made to Allied Hearing for any services furnished to me by any provider. I authorize any holder of medical information about me to be released to my referring doctor, insurance company, or to the Health Care Financing Administration. I understand that it is my responsibility to pay deductible, copays, coinsurance, upgrade fees (above basic aids) or any other balance not paid for by my insurance. I authorize said assignee to release all information necessary to secure the payment. I acknowledge that I have been presented with Allied Hearing's notice of privacy practices.

** Patient/Guardian Signature **

Signature: _____ Date: _____
(Patient, parent, or legal guardian)

If signed by patient representative, state relationship to patient: