CLEAR CHOICE
AUDIOLOGY, LLC.

36 McMillen Drive
Newark, OH 43055 (740) 344-1304

I. CONSENT AND RELEASE

The Audiologist and/or my doctor may determine that treatment, procedures or examinations are advisable during my office visit. I hereby give my consent to Clear Choice Audiology, LLC and staff, to perform such tasks. This includes using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address provided.

II. FINANCIAL RESPONSIBILTY AND ASSIGNMENT OF BENEFITS

I am personally responsible for the payment of all charges incurred through Clear Choice Audiology, LLC, including payment of fees charged by a collection agency in the event my account becomes delinquent. It is my responsibility to check with my insurance company to make sure Clear Choice Audiology, LLC is "In Network" before I am treated. If Clear Choice Audiology, LLC is "Out of Network" I understand that I will be responsible for all charges. I hereby assign to them and/or their audiologist all benefits due from any insurance policies or employee health care benefit programs. I authorize and direct such policies or programs to make payment directly to Clear Choice Audiology, LLC.

III. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize Clear Choice Audiology, LLC to release medical information to any physician treating me during this visit or any physician treating me for follow up care. I authorize release of this information to the insurer or its agents processing the claim for payment.

IV. PRIVACY NOTICE

By signing this form, you are granting consent to use and disclose your protected health information for the purposes of treatment, payment and health care operations. You have the right to request that we restrict this use, however we are not required to grant your request. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our policy before you sign this consent, and we encourage you to read it in full. Our policy is subject to change, and you can obtain a copy of the revised notice by contacting us at (740) 344-1304. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

_____ _____

Patient Signature Signature of Responsible Party (If Child)

_____

Date