Aurora audiology

Policy Authorization

Please read all and sign below:

I ACKNOWLEDGE THAT I HAVE READ AND/OR RECEIVED A COPY OF AURORA AUDIOLOGY **NOTICE OF PRIVACY PRACTICES**. I also consent to the use or disclosure of my protected health information (PHI) by Aurora Audiology for the purpose of treatment, payment and health care operations.

- I understand service to me may be conditioned upon my consent as evidenced by my signature on this document. ❒ **Refuse to sign***
- I understand I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or health care operations of the practice. **Please refer to the Aurora Audiology Notice of Privacy Practices for how this restriction is honored.**
- I understand my PHI means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, and a health care clearinghouse. This PHI relates to my past, present or future physical or mental health or condition and identifies me; or, there is a reasonable basis to believe the information may identify me.

I HAVE RECEIVED AND READ AND/OR RECEIVED THE **FINANCIAL POLICY** OF AURORA AUDIOLOGY:

- I understand that, if I have health care insurance, my guardian or I am responsible for any portion of the bill that insurance denies or does not cover.
- I understand that, if I do <u>not</u> have insurance, my guardian or I am responsible for all fees related to services rendered <u>at time of service</u>. I understand that any charges verbally quoted are considered estimates and are not guaranteed.
- **I understand that any invoicing will be sent three (3) times by Aurora Audiology to my <u>preferred method (Check all that apply): ❑ email ❑ text</u>**

I HAVE RECEIVED AND READ AND/OR RECEIVED THE **NO SHOW POLICY** OF AURORA AUDIOLOGY:

- I understand that my account may be charged a $50 “no-show” service charge if I do not cancel or reschedule an appointment with a 24-hour notice. I understand that this “no-show charge” is not reimbursable by my insurance company and I will be billed directly for it.
- I understand that after three consecutive no-shows, Aurora Audiology may decide to terminate our relationship.

Printed Name: ______________________ DOB: __________

Patient’s Signature: ______________________ Date: __________

Parent or Legal Guardian or POA: ______________________ Date: __________

**In case of refusal to sign or revoking of the acknowledgement of privacy practices, this organization may refuse to treat you as permitted by Section 164.506 of the Code of Federal Regulations.*