Consent for Treatment

I voluntarily give my permission to the health care providers of Silver State Hearing and Balance, as they may deem necessary to provide services to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care or until I withdraw my consent in writing.

_____ _____

Signature **Date**

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I understand this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____ _____

Patient Name **Signature of Patient or Parent/Guardian** **Date**

Financial Agreement

Silver State Hearing and Balance participates in many insurance plans, but not all of them. It is your responsibility to know whether the doctor you are seeing is a participant on your plan. Charges for services rendered by Silver State Hearing and Balance will be submitted directly to your insurance company for payment, as a courtesy to you. You will be responsible for any amount not paid by your insurance. Should you not have insurance coverage, you will be responsible for payment at the time of your visit. All copays are due at the time of service.

I authorize Silver State Hearing and Balance to release any information acquired during my examination and treatment for the purpose of claim payment. I further authorize payment directly to Silver State Hearing and Balance for benefits due me for this service. I recognize and accept personal responsibility for any balance remaining after payment of such benefits.

_____ _____

Signature **Date**