Moore Audiology and Hearing Aid Center

623-825-0999
Fax: 623-875-6632

WWW.mooreaudiology.com mooreaudiology@gmail.com 10503 W Thunderbird Blvd - Sun City, AZ 85351

Glad you are "Hear"! Please complete the information below and sign.

First Name:_____ Last Name: _____

Date of Birth: _____ Age:_____ Sex:_____

Address _____ City:_____ Zip:_____

Home phone number: _____ Cell phone number: _____

E mail:_____ Spouse's Name:_____

Primary Care Physician: _____ Referring Physician: _____

How did you hear about Moore Audiology & Hearing Aid Center?

_____

PERSON RESPONSIBLE FOR BILL (if other than patient)_____

PERSON TO CONTACT IN CASE OF EMERGENCY (different from patient)

Name:_____ Relationship:_____ Phone Number:_____

Address:_____

INSURANCE INFORMATION

Insurance Company:_____

Please present your insurance card(s) and a photo ID to the front desk.

I assign all medical and/or surgical benefits to which I am entitled, under private insurance, or any other health plan. I authorize the release of my medical information necessary to process claims and direct payment of benefits from my insurance company. I accept financial responsibility for all charges, including but not limited to, copayments and annual deductibles. I have received my Medical Treatment Agreement. * This includes my email and phone communication preferences as well as, the Consent to Treat agreement.*

_____ _____

Signature Date

Moore Audiology & Hearing Aid Center

10503 W. Thunderbird Blvd.
Suite #114
Sun City, AZ 85351
(623) 825-0999

MEDICAL TREATMENT AGREEMENT

Patient or the patient's legal representative agrees to the following terms of Audiology and Hearing Aid Center Office encounter:

1. **MEDICAL TREATMENT:**
   The patient consents to the treatment, services and procedures which may include but are not limited to hearing evaluation, hearing testing, hearing aid fitting and consulting, and ear washes.
2. **LEGAL RELATIONSHIP BETWEEN OFFICE AND HEALTH CARE PROVIDERS:**
   The patient will be treated by Dr. Moore and/or other health care providers in his offices and be under his/her care and supervision.
3. **TEACHING PROGRAM:**
   The Office participates in training programs for physicians and health care personnel. Some patient services may be provided by persons in training under the supervision and instruction of physicians or Office employees. These persons in training may also observe care given to the patient by physicians and Office employees.
4. **RELEASE OF INFORMATION:**
   A. The patient acknowledges and agrees that medical and/or financial records (INCLUDING INFORMATION REGARDING ALCOHOL OR DRUG ABUSE, HIV RELATED OR OTHER COMMUNICABLE DISEASE RELATED INFORMATION) may be released to the following: Healthcare providers or their agents who are providing or have provided health care to the patient; any individual or entity responsible for payment to Audiology and Hearing Aid Center Office or other provider's charges; to healthcare providers or organizations accrediting the facility or conducting utilization review, quality assurance, or peer review; and to the Office's and provider's legal representatives and professional liability carriers.
   B. Individuals and organizations engaged in medical education and research, provided that information may only be released for use in medical studies and research without patient identifying information.
   C. Individuals and entities as specified by federal and state law and/or in the Office's Notice of Privacy Practices.
   D. Patient records of services provided at Audiology and Hearing Aid Center Office may be exchanged amongThese facilities where necessary to provide appropriate patient care. This Release shall continue for so long as the medical and/or financial records are needed for any of the above-stated purposes. This is an assignment of benefits of my rights and benefits under my insurance. I authorize the release of any medical information necessary to process claims and direct payment of benefits from my insurance company.
5. **CONTRABAND:**
   Drugs, alcohol, weapons and other articles specified as contraband by the Office may not be brought onto Office premises. Any illegal substance will be confiscated and turned over to law enforcement authorities.
6. **PHOTOGRAPHS/TAPED THERAPY SESSIONS:**
   I understand and agree that a photograph may be taken of me for identification purposes or for other treatment purposes I further agree that therapy sessions may be taped (audio and/or videotaping) and that all photographs and tapes will remain the property of the Office. I will not take pictures of the staff without their permission.
7. **COMMUNICATION:**

☐**Okay** to call my home and leave a message. ☐Call my home phone but **do not** leave messages.

☐**Do not** call my home phone, **call only** this number. ( )_____-_____ ☐**cell phone** ☐**other**

May we leave a message on this phone? ☐**Yes** ☐ **No**

☐**Do not** speak to family members.

I authorize the following individuals to inquire and receive verbal information regarding my care.
(Actual release of medical records requires a separate form).

1._____

2._____

Electronic Request: ☐E-mail ☐CD **Paper** Request: ☐

Email Address for record delivery																									

I have received the Notice of Privacy Practices. I am the patient, the parent of a minor child, or the legal representative of the patient and am authorized to act on the patient's behalf to sign this agreement.

_____
Patient / Parent of Minor Child / Court-Appointed Guardian
Patient-Appointed Agent / Statutory Surrogate
Please circle the correct title

_____
Witness:

_____
Date: Time:

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HIPAA

(Health Insurance Portability and Accountability Act)

Why do I have to sign this form?

In 1996, the Federal Government passed the Health Insurance Portability and Accountability Act. HIPAA has several components; one component mandates that Moore Audiology and Hearing Aid Center, and other healthcare organizations obtain a patient's acknowledgement of receipt of the Notice of Privacy Practices. This receipt must be obtained prior to any appointments occurring on April 14th, 2003 or thereafter.

The law is clear the "acknowledgement of receipt" of the practice is all that is required. You need only sign this form once; it will not be required for future visits with Moore Audiology and Hearing Aid Center providers.
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Notice of Privacy Practices

Patient Name _____

I, _____ have received a copy of Moore Audiology And Hearing
Patient Signature
Aid Center of Privacy Practices on _____.
Date

_____ _____
Legal Authorized Representative if not patient Date