PHILIP AUDIOLOGY
& HEARING AID SERVICES
Professional Mobile Hearing Care You can Trust

PATIENT CONSENT FORM

With my consent and signature, Philip Audiology & Hearing Aid Services may use and disclose protected health information about me to:

- Carry out any type of services related to treatment, payment, and healthcare operations
- Call my home or other designated location and leave a message on voice mail in reference to any related services to the clinic (i.e., appt reminder)
- Mail to my home or other designated address any item such as a financial bill or appt reminder card
- Email correspondence for all of the above similar items and purposes
- To use and/or disclose protected health information about me to/with third parties involved in my care if need be. Such parties may include a physician, hospital, and/or insurance company

Consent for Telehealth Services:

Telehealth services if and when conducted involves transmitting of videos and/or details of my medical records and test results. All data is sent by secure electronic means to the Providers to facilitate the service being performed. I understand that:

- I will be informed of any other people who are present at either end of the telehealth encounter, and have the right to exclude anyone from either location
- All confidentiality protections required by law or regulation will apply to my care
- I have the right to refuse or stop participation in telehealth services at any time and request alternate service such as an in-person appt. However, I understand that equivalent in-person services might not be available at the same time as telehealth service
- If I do not want to receive health care services by telehealth, it will not affect my right to future care or treatment, or any other insurance/program benefit to which I would otherwise be entitled
- I have the right to review the Notice of Privacy Practices of Philip Audiology & Hearing Aid Services. I may request a copy at any time

I may revoke this entire consent, in writing at any time. If I don't sign this consent, or revoke this consent, Philip Audiology & Hearing Aid Services may decline further treatment of me

Patient Name_____

Signature _____ Date_____