Assignment of Benefits/Release of Information, Financial Responsibility, Treatment Consent, and Privacy Policy Authorization

Name of Patient: _____ Date of Birth: _____

Please check all items as read and sign below:

____ **Assignment of Insurance Benefits/Release of Information:** I hereby authorize my Medicare and/or medical insurance benefits to be paid directly Oconee Audiology, separately from other facility or professional bills. I understand that I am financially responsible for non-covered services as well as any deductibles, coinsurance or amounts in excess of insurance benefits. If coverage is denied, I give my express consent to appeal to the insurance on my behalf.

I hereby authorize Oconee Audiology, to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records to the following:

a. Any person or entity responsible for payment for the medical services rendered to me at the Oconee Audiology, including third party payers, self-insurers, worker's compensation carriers and government agencies or any person or entity acting as the agent or contractor of such party responsible for payment, in connection with obtaining payment for the medical services rendered to me by employees of Oconee Audiology or any person providing services at Oconee Audiology.
b. Federal, State or other governmental agencies or such other parties required by law for reporting purposes or for purposes of determining eligibility in government sponsored benefit programs.
c. Any health professionals involved in my care for the purpose of facilitating the continuity of my medical care including my personal primary care physician, or any other referring physician.

Additionally, I authorize that my personal information and information may be accessed by and disclosed to those listed below:

Name	Relationship to Patient
_____	_____
_____	_____

____ **Consent for Treatment**: I voluntarily consent to audiologic diagnostic testing and treatment by Oconee Audiology that is considered necessary for the care and treatment of my hearing needs.

____ **Communications**: I give Oconee Audiology permission to contact me with information regarding scheduled appointments, treatments, updates, newsletters, etc. by the following means of communication:

Choose all that apply: _____ Text _____ Email _____ Phone _____ Work _____ Mail

____ **Receipt of Privacy Notices:** I acknowledge receipt of Oconee Audiology's Privacy Policies and understand the information contained in the document. I understand that a copy of these policies is accessible on the Oconee Audiology website, and I can also receive a printed copy at my request.

I acknowledge that the above authorization has no expiration date and is valid to authorize the release of medical records and billing information at any time a valid request is received.

A copy of this form shall have the same force and effect as the original.

I acknowledge that I have read and understand its contents fully. The undersigned is the patient, the patient's legal representative or is authorized by the patient to execute this form and accepts its terms.

_____ _____

(Signature of patient, parent or legal guardian of patient) (Date signed)