RHODES
CENTERS FOR BETTER HEARING

Name _____ DOB: _____

Address _____ City _____State_____ ZIP _____

Best Number (____) ____-_____ Secondary Phone (____) ____-_____ Email _____

How would you prefer to be contacted for follow up care? ☐ Text ☐ Email ☐ Phone ☐ Letter

Insurance Type _____ Employer _____ Occupation _____

Did you retire from Honeywell, USEC, Caterpillar or Cook Coal? ____ Where did you retire from? _____

☐ Married ☐ Single ☐ Widowed ☐ Divorced

Who is your family doctor? _____ (A copy of your report will be faxed to your physician)

Have you seen our ads: TV, what channel? _____ Website, how did you find our site? _____

Newspaper, what paper? _____ Other, please specify? _____

What motivated you to choose us as your preferred provider? _____

Did someone refer you to us? Who? _____

Health Insurance Portability & Accountability Act of 1996

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to: (A) Provide and coordinate my treatment among health care providers who may be involved in that treatment. (B) Obtain payment from third-party payers for my health care services. (C) Conduct normal health care operations such as quality assessment and improvement activities. (D) Communicate information related to hearing care products or services.

I have been informed of Rhodes Centers for Better Hearings *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that Rhodes Centers for Better Hearing has the right to change the *Notice of Privacy Practices* and that I may contact this office 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 and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide.

Sign _____ Date _____

You may disclose my protected healthcare information to the following: (Check One)

☐ None, only disclose my protected health information to the parties in the *Notice of Privacy Practices*.

☐ Disclose my protected health information to the parties in the *Notice of Privacy Practices* and the following: (ex. spouse, child)

Name/s_____