Acknowledgment of Receipt of Privacy Practices Notice

By signing this form, you acknowledge receipt of the Notice of Privacy Practices from our company. The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. The Notice of Privacy Practices is subject to change. If the Notice is changed, you may obtain a revised copy by contacting us at the address below.

I acknowledge receipt of the Notice of Privacy Practices from your company.

_______________________________ _______________

Patient Signature *Date*

Office Use Only
We attempted to obtain the patient's signature to acknowledge receipt of our *Privacy Practices Notice*, but were unable to do so. HIPAA laws require we keep record of attempt to obtain acknowledgment.
Date_____________ Initials _______________ Reason: ___________________________
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RECORD OF ACKNOWLEDGMENT TO REMAIN IN PATIENT FILES AT ALL TIMES

Consent to Telephone Contact

I hereby give my consent for your company, or entities calling on its behalf, to call my home or other alternative locations and leave a message on voice mail or in person in reference to carrying out treatment, payment or operational activities such as appointment reminders, insurance items and any calls pertaining to my hearing health care.

This permission shall remain in effect as long as I have not revoked my consent in writing and asked to be placed your do-not-call list. Signing this form does NOT obligate me to make any purchases or otherwise respond to calls from your company.

_______________________________ _______________

Patient Signature *Date*

Please fill in the phone number(s) we have your permission to use to contact you.

Home Phone ______________________ **Cell Phone** ______________________

Hearing, Balance & Speech Center

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