Insurance Information and HIPPA Guidelines

- Please give your insurance information and identification card to our front office staff so we can make a copy for our records.

- Please read carefully, and circle "YES" or "NO" where it applies to the following statements:

1. I give permission to Lawson's Hearing Center to release information, verbal and written (contained in my medical record and other related information), to my insurance company, related healthcare providers (your doctor), assignees and/or beneficiaries. **YES / NO**

2. I give permission to Lawson's Hearing Center to release information, verbal and written (contained in my medical record and other related information), to my rehab nurse, case manager, attorney, employer and all other related persons. **YES / NO**

3. I authorize Lawson's Hearing Center to release my protected health information for marketing related to hearing care products or services. I understand that the practice may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described. I understand that this marketing authorization is in effect until a revocation is received by the practice. **NO**
(LHC does not participate in this type of marketing, but must inform you based on HIPPA guidelines.)

- By circling "YES" to any of the boxes above, I also authorize this information to be faxed. Lawson's Hearing Center will not condition treatment based on your responses.

Permission Statement

I, _____, hereby authorize Lawson's Hearing Center, to share any and all medical, financial, or personal information about me with the individuals mentioned below.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

- With your signature below, you agree to the following:

  - I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office and that authorizations given are valid until revoked by you in writing.
  - I have read and understand all of the information on this form, and certify this information is true and correct to the best of my knowledge and hereby give Lawson's Hearing Center permission to treat my concerns.

Patient Signature_____ Date ____/____/____

Parent/Guardian Signature _____ Date ____/____/____