I authorize release of information necessary to file a claim with my insurance carrier and request payment of benefit either to myself or to Audiology Partners, LLC if the fee has not been paid. I understand that I am financially responsible for any balance not covered by my insurance carrier. **Medicare only:** I request that payment of authorized Medicare benefits be made either to me or on my behalf to Audiology Partners, LLC for any services furnished to me by that audiologist. I authorize any holder of medical information or any information needed to determine benefits of the benefits payable for related services for me to be released to the Healthcare Financing Administration or its agents. I also understand the Medicare does not cover the cost or related cost of a hearing device.

Patient's
Signature_____Date:_____

ACKNOWLEDGEMENT OF RECEIPT OFAUDIOLOGY PARTNERS, LLC
NOTICE OF PRIVACY PRACTICES

I HEREBY ACKNOWLEDGE THAT I HAVE READ/RECEIVED A COPY OF AUDIOLOGY PARTNERS, LLC'S NOTICE OF PRIVACY PRACTICES.

Personal or Representatives Signature: _____

Print Patient Name: _____ Date: _____

Print Name of Personal Representative, if applicable: _____

AUDIOLOGY PARTNERS, LLC USE ONLY

If signed acknowledgment not received, document good faith efforts used to obtain:

_____

_____

REVISED 1.1.2017