MORNINGSIDE AUDIOLOGY
Contact: (712) 560-1488

HIPAA and Insurance Form

PERSONAL

Name _____
Title First M Last

Address _____

City _____ State _____ Zip Code _____

Date of Birth _____
MM/DD/YYYY

Phone Number _____ Email _____

ALTERNATE CONTACT

Name _____
Title First M Last

☐ Is primary contact

☐ Signing on behalf of patient

Address _____

City _____ State _____ Zip Code _____

Relationship to patient _____

Home phone _____ Mobile phone _____

PATIENT HIPAA

I understand that I have certain rights to privacy regarding my protected health information according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize the clinic to use and disclose my protected health information for the purpose of:
- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from insurance or third-party benefit plans;
- The day-to-day healthcare operations of the clinic such as quality assessments and provider certifications.

INSURANCE AND PAYMENT

I authorize the clinic to provide medical treatment and file my insurance and third-party benefit claims. I authorize payments of medical benefits to be paid directly to the clinic. I accept full responsibility of all services and charges not paid for by my insurance company or third-party benefit plan.

I accept full responsibility for all charges in the event that I have no insurance or third-party benefits. Charges 30 days past due are subject to late fees.

PATIENT

Patient signature or Legal Guardian _____
Please sign here Date