ALEXANDRIA HEARING CENTERS, MASSA & ASSOCIATES

Patient Authorization & Privacy Acknowledgment Form

Patient Name: _____

I have been given a copy and have read the **Notice of Privacy Practices**, which explains how my medical information will be used and disclosed. I authorize the release of my medical information necessary to evaluate and/or treat my condition, to process insurance claims on my behalf, and for other necessary health care operations of Alexandria Hearing Centers, Massa & Associates.

I authorize Alexandria Hearing Centers, Massa & Associates to apply for benefits from Medicare and any other insurance carrier, and payment is to be made directly to Alexandria Hearing Centers, Massa & Associates. Responsibility for payment remains with the patient regardless of insurance coverage. The patient will also be responsible for any collection or attorney's fees incurred.

Authorization for Disclosure of Patient Information

In general, the **HIPAA Privacy Rule** gives individuals the right to request restrictions on uses and disclosures of their protected health information (PHI). Individuals may also request confidential communications of PHI. The patient may revoke or change this authorization at any time with a written request.

Preferred Contact Methods (check all that apply):
☐ Telephone ☐ Email ☐ Text

Numbers where messages may be left:
Home _____ Work _____ Mobile _____

Authorized Family Members:
Name _____ Phone # _____ Relationship _____

Appointment Reminders

Our office will send an appointment reminder **48 hours prior** to your scheduled appointment. If you need to cancel, please give **24 hours' notice**. Failure to do so may result in an office charge.

Patient Signature: _____ **Date:** _____