SOUND
HEARING & BALANCE

Registration Form *(Please Print)*

Todays date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:		☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former Name):	Birth date: / /	Age: Sex: ☐ M ☐ F
Street address:		Social Security No.:		Home phone no.: ( )
P.O. box:	City:	State:	ZIP Code:	
Occupation:	Employer:	Employer phone no: ( )		
Chose clinic because/Referred to clinic by (please check one box) ☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other		Dr. _____ ☐ Insurance Plan ☐ Hospital		
Other family members seen here:				

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of the privacy practices for Ohio Sinus Institute, which Sound Hearing and Balance abides by, and have therefore been advised of how certain health information about me may be used and disclosed by Sound Hearing and Balance, as well as how I may obtain access to and control this information.

CONSENT FOR TREATMENT AND HEALTH CARE OPTIONS

In providing service to you, we create and store health information about you that identifies you. We understand that this information about you and your health is personal and are committed to protecting the privacy of this information. We must obtain your written consent before we treat you, obtain payment or provide services at Sound Hearing and Balance.
Please read the information below before signing this form.

Scope of consent: By signing this consent form you will permit Sound Hearing and Balance to use your protected health information for treatment, payment and normal business operations. You also permit our staff to share your information with other persons or organizations outside this practice that perform payment activities and business operations jointly with the practice.

Notice of Privacy Practices: We have a notice of privacy practices that describes the uses and disclosures in detail and encourage you to read it. We want you to know, however, that this notice of privacy is subject to change. If it is changed you may request a copy of the revised notice at your next visit or by calling the office.

Restricting Use and Disclosure: You have the right to ask us to restrict the uses or disclosures of your protected health information. Sound Hearing and Balance is not required to agree with this restriction but if it does it will be bound by the agreement unless the information is needed to provide you with emergency treatment or comply with the law.

Revoking Consent: You have the right to revoke this consent at any time, except to the extent that Sound Hearing and Balance has provided you with treatment; the practice will be permitted to use and disclose your personal health information to bill for that treatment. To revoke this consent please contact our office.

I also consent to be contacted by phone and email if an email address has been provided.

Signature of Patient or representative: _____ Date: _____

Print name of Client: _____

Print name of personal representative if applicable: _____