Authorization & NPP Receipt

435 King Street, Suite 2 Littleton, MA 01460
Phone: 978-952-2500 Fax: 978-952-2502

Authorization and Release

I authorize the release of pertinent information necessary to process my medical claim. I hereby assign all insurance benefits to which I am entitled, including Medicare, private insurance and any other health plans to **HearSmart Audiology** for services rendered. The assignment will remain in effect until revoked by me in writing. I understand that if my insurance requires a referral, I am responsible for obtaining one prior to my appointment. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all other services rendered on my behalf.

I also authorize **HearSmart Audiology** to release any and all medical information in the course of my treatment to my primary care physician, as well as to:

_____

(Name) (Location)

Late Charges

If I do not pay the balance within 30 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is repayment for additional services. In the case of default on payment of the account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding balances.

HIPAA Statement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name_____ Date_____

Relation to Patient_____

Signature_____