PATIENT INFORMATION FORM

PATIENT NAME: (Last) ______________________________(First)______________________________ (Middle Initial) _______

ADDRESS: ____
(Street) (City, State, Postal Code)

DATE OF BIRTH:___________________________________ E-MAIL*:____

TELEPHONE NUMBERS: (______)_______________________________ (______)_______________________________________
(Home) (Cell OR Work CIRCLE ONE)

MAY WE E-MAIL OR TEXT APPOINTMENT CONFIRMATIONS TO YOU*? Yes □ No □
*Confirmation will include clinic location and time of your appointment

RESPONSIBLE PARTY NAME: ____PHONE: _______________________________

PATIENT RELATIONSHIP TO RESP. PARTY: SELF CHILD PARENT SPOUSE EMPLOYEE

PRIMARY PHYSICIAN NAME:____

PHYSICIAN ADDRESS:____
(Street) (City, State, Postal Code)

PHYSICIAN TELEPHONE:____ FAX:___________________________

EMERGENCY CONTACT NAME:____PHONE:_________________________

---

1. Are you a previous patient? Yes □ No □ If yes, which office_________________________________
2. How did you hear about us?____
3. Is this visit covered by a Health Insurance Plan or any other payors? Yes □ No □

   (Example of other payors: Worker Compensation, a secondary health insurance plan, a family member's insurance plan, your Employer, etc.)

   If yes, please present your member identification card and/or referral if applicable.

CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, you are granting consent to Lifestyle Hearing Corporation (USA), Inc., its subsidiaries and/or affiliates to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Policy provides more detailed information about how we may use and disclose this protected health information.

Although we do not sell or release patient information to third parties, we do give you the opportunity to receive promotions or information about our products and services. If you prefer NOT to receive communications about products or services, please check here to set your contact preference to "no contact." □

You may choose another person to help with your clinical visits or speak to us by phone. This person requires your written permission to discuss your treatment and your private health information with our staff. If you choose to give this permission to someone, please designate that individual and your relationship to them. If no one, please leave this blank.

____ (full name), _________________________________ (relationship).

You have a legal right to review our Notice of Privacy Policy before you sign this consent, and we encourage you to read it in full. You have the right to request a copy of this notice for your personal records. Our Notice of Privacy Policy is subject to change. A current copy will remain available in our clinics.

You have a right to request that we restrict how we use and disclose your protected health information for the purposes of marketing, treatment, payment or health care operations. Depending on the nature of your request, we are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

In order to provide you with the best customer service and patient experience, your appointment may be monitored or recorded for quality and training purposes. If you do not wish to have your appointment monitored or recorded, please check this box □.

_________________________________ _________________________________
Signature Date