## Hearing & Balance Center CONSENT FOR TREATMENT

I, the undersigned, having a condition requill encompass routine diagnostic procedudgment. I understand that Audiology is as a result of treatment. This consent is disorders which was initiated on (date)	edures and treatment s not an exact science a for testing and treatm	by the audiologist as is n and that no guarantees have ent rendered for my hearing	been made to me ag and/or balance
Authorization is hereby granted to relea hearing and/or balance disorder, including			
FINANCIAL GUA	RANTEE AGREEM	ENT AND RELEASE	
Assignment of Benefits: I hereby authori insurance benefits or payments from any of Guarantee of Account: I understand that all charges incurred during treatment. If punderstand that I am financially responsible an insurance company or third-party payor Release of Information: I hereby authorinformation from my medical record to welfare agency or any other person or consultant and attorneys who need such in Medical Record Review: To secure pay your employer, insurance company, or to authorize any representative of The Heart this claim to any person or organization in Medicare Patients Only: I certify that the Social Security Act is correct. I author to the Social Security Administration and/Review Organizations any information in authorized benefits to be made on my behamed the Medicare-Acknowledgment of Receipmessage from Medicare and The Hearing or make me liable for any payment.	other third-party payor, at I am financially respondent is not made by belie for the charges for to be, in their judgment is The Hearing & Barrize responsible for formation for the efficit formation for the efficit formation for the efficit formation, but not limited the information given morize any holder of med for the Medicare Programeded for this or a relialf.  t: My signature only	otherwise payable to me. onsible to The Hearing &B an insurance company or the services provided, even int, not necessary. alance Center, Inc. to release, third-party payors, More payment for such servicent operation of the office. cord may be reviewed by a as a patient and/or respons. Inc. to release any and all it to, insurance carriers and ene applying for payment unlical or other information alternation of its intermediaries or cated Medicare claim. I reacknowledges my receipt	salance Center for hird-party payor, later if determined by see such treatment edicare/Medicaid ces, and to such representative of ible party hereby information about employers. der Title XVII of yout me to release arriers or the Peer quest payment of this important
<b>Consent for Treatment?</b>		YES	NO
Have you been given a copy of HBC's Notice of Privacy Practi		tices? YES	NO
Given "Statement of Patient Rights" under Ohio Law?		YES	NO
Given Important Message from Medicare?		YES	NO
Witness	Date	Signature of Patient or	Representative
Authorized Representative	Date	Relationship to Patient	

04/01/2004 tjn

Form 1860