VIRSONO Hearing Center

Welcome to Virsono Hearing Center

Please complete all fields

Legal Name_____ DOB ____/____/____
First MI Last mm dd yyyy

Preferred Name _____ Age _____ Sex M F

Home Phone _____ Cell Phone _____ Email Address_____

Which method of communication do you prefer? ☐Phone Call ☐Email ☐Text

Mailing address _____
Street City State ZIP

Marital status ☐ Married ☐ Single ☐ Widowed ☐ Other

Spouse/Partner Name_____ DOB ____/____/____
First MI Last mm dd yyyy

Emergency contact_____ Phone # _____

Relation to patient _____

Employment Status ☐ Full-time ☐ Part-time ☐ Self-Employed ☐Not Employed ☐ Retired

Primary Language _____

How did you hear about us? ☐ Mail ☐ Newspaper ☐ Radio ☐Physician ☐ Seminar
☐ Virtual Consultation ☐ Health/Senior fair ☐ Website ☐ Employer ☐ Friend _____
☐ Referred by physician _____ ☐Other _____

Reason for today's appointment _____

Primary Care Physician _____ City _____ Phone _____

A copy of your complete audiology report will be sent to your Primary Care Physician (PCP).
If you do not want a copy sent to your PCP, please check this box: ☐**No**

VIRSONO
Hearing Center

Please read carefully and sign below:

- You give your consent for Virsono Hearing Center to use and disclose your protected health information (PHI) in the provision of healthcare services to include treatment, payment activities, and healthcare operations. This includes allowing Virsono Hearing Center to send reminder appointment post cards/text messages/emails and to also leave voice messages, including instructions on phone recorders, at home or work – confirming the details of your appointments.
- You also consent to Virsono Hearing Center notifying you of upcoming events, special promotions, new products, and other services and information.
- You acknowledge that you have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
- In accordance with current telemedicine best practices, your appointment will be video recorded. The recording will only be used for Quality Assurance (QA) purposes, to support and improve the programs or services we offer.
- We reserve the right to change our privacy practices as described in our notice of privacy practices. If we change our privacy practices, we will issue a revised notice of privacy practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
- Right to revoke: You will have the right to revoke this consent at any time by giving Virsono Hearing Center written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on your consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.
- We may discuss your hearing health care with the following individuals:

_____ _____

I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge, and I hereby give Virsono Hearing Center permission to treat my concerns.

_____

Patient Signature Date