Lifetime HEARING SERVICES, INC.

Lesley Kirby, AuD
Doctor of Audiology
843-662-HEAR (4327)
Fax 843-662-4395
522 W. Palmetto St., Florence, SC 29501

MEDICARE PARTICIPANTS: LIST OF CURRENT MEDICATIONS

Recipients of Medicare Benefits are required to provide a current list of medications prior to receiving medical treatment. Please indicate your current medications, (including prescriptions, over the counter, herbals, vitamin/dietary supplements), and include the drug name, dosage, frequency and how to administer the medication (oral, injection, suppository).

Please review the statements below and by signing, you are indicating the following to be true and correct as of the date of your examination with us.

List of Medications Provided
I have provided the attached list of Current Medications to Lifetime Hearing Services and certify this to be accurate and current as of today's date. Please include your printed name, date and signature on the attached list of medications.

Signature:_____ Dated:_____

I do not have any medication information to provide
I am not currently taking any medications, (including prescriptions, over the counter, herbals, vitamin/dietary supplements) as of the date of this examination.

Signature:_____ Dated:_____

List of current medications:
I am taking the medications listed below:

Medication	Dosage	Frequency	Route/Method

Signature:_____ Dated:_____

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THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Protecting your privacy and security of your personal information is important to us. We will not sell or assign your personal information and take appropriate security measures to protect your information. As appropriate, we do have to communicate and share information with your doctor and insurance company.

Please review the statements below and by signing, you are indicating you have had an opportunity to review our privacy agreement; you are granting us permission to send reports to your doctor(s) and file insurance claim(s; and in the event any services provided are not paid by your insurance, you will be responsible to pay the balance owed to this office.

Privacy Policy
I have had an opportunity to review and ask questions about the Lifetime Hearing Services Privacy Policy.

Signature:_____ Dated:_____

Authorization to release information
I authorize Lifetime Hearing Services to furnish information concerning my treatment to insurance carriers, physicians and or referring agencies that provide appropriate releases.

Signature:_____ Dated:_____

Assignment of Benefits
I understand Lifetime Hearing Services may elect to file a claim with my insurance carrier as an accommodation for me. I authorize Lifetime Hearing Services to collect payment directly from my insurance provider for covered services. In the event the claim is deemed a non-covered services, or an additional amount is due and allowable, I will pay Lifetime Hearing Services within seven days of receipt of a statement for amounts due.

Signature:_____ Dated:_____