



All Ears Audiology, Inc.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONFIDENTIAL CONTACT INFORMATION

NAME OF PATIENT: _____

TELEPHONE: _____

DATE: _____

SIGNATURE: _____

RELATIONSHIP: _____

WHERE CAN WE CONTACT YOU? (Please check all that apply)

Work _____

Home _____

Cell _____

CAN WE LEAVE MESSAGES ON YOUR ANSWERING MACHINE

OR WITH ANOTHER PERSON WHO ANSWERS?

YES _____ NO _____

PRIVACY CONTACT

All Ears Audiology, Inc.