ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This acknowledges my receipt of (Atlanta) Hearing Associates's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

_____ _____

Printed name of patient or personal representative Date

_____ _____

Signature of patient or personal representative Date

_____ _____

Printed name of witness Date

_____ _____

Signature of witness Date

PATIENT CORRESPONDENCE

The only known treatments for permanent hearing loss are hearing aids, surgically implanted Cochlear Implants/Bone Anchored Hearing aids and various therapy programs to improve your performance of these products. Additionally, new product devices continue to be released that may interface with hearing aids. As your hearing healthcare provider, communication with our patients is necessary in providing education, treatment and rehabilitation options for your hearing loss. This consent allows Hearing Associates to maintain a more continuous quality of care for our patients.

_____ _____

Signature of Patient Date