VHS HEARING SOLUTIONS
Better Hearing Starts Today

Parent Consent Form/Medical Release Form

I understand that Virtual Hearing Solutions (VHS) requires a signed consent for Covid-19 testing. I understand I need to sign it before my child can be tested. I,_____, give consent to VHS and its employees and/or contractors to examine and test my child _____ and/or myself by signing this form. I understand that: I can cancel this Consent in writing. If I notify VHS in writing to cancel this Consent, VHS may no longer examine and treat the patient; and that there are no guarantees for outcomes and results. VHS will be responsible for all specimen handling and the performance of all testing.

SPECIMENS AND BLOOD TESTING I understand that a health care provider may accidentally come into contact with the patient's body fluids. If this happens, I consent to testing the patient for infectious diseases. I agree that the exposed person may be given the results. I understand that the law may require VHS to report some medical outcomes to the government.

PARENT CONTACT INFORMATION AND USE OF HEALTH INFORMATION I agree to tell VHS how to reach me such as by phone, cell phone, fax, mail, or e-mail. By providing VHS with my cell phone and/or landline phone, I agree to be contacted via text message, voice and/or recorded call by VHS or its contracted business associates for all healthcare calls to include: appointment reminders, pre-registration instructions, prescription notifications, accounting, billing, or debt collection. I understand that VHS follows all federal and local laws including the Health Insurance Portability and Accountability Act. I understand that this Consent allows VHS to use private health information for treatment, payment and hospital operations as defined in the Notice of Privacy Practices. I agree that VHS may use de-identified health information about the patient for approved research and quality improvement activities.

PAYMENT, INSURANCE, AND ASSIGNMENT OF BENEFITS AUTHORIZATION I assign to VHS the right to bill and collect from any insurance that covers the patient. I agree to help VHS seek payment and to tell VHS about any resources for payment of the patient's bill.

PATIENT IDENTITY My signature below means that I have given truthful information about the patient's name and identity. It also means that I understand: How important it is to provide truthful and accurate information about the patient's name and identity. That incorrect or false information about identity can lead to treatment that could be harmful to the patient. That VHS reserves the right to take action for intentional presentation of false information including transfer of care and appropriate reporting to authorities.

MEDICAL RELEASE:

I authorize the release of medical information pertaining to my Covid-19 examinations and results rendered to me and claims information. This information may be released to _____.

Patient Name: _____

Signature of Parent/Legal Guardian _____

Date/Time: _____

Relationship to Patient_____ Phone Number _____