Abington Audiology & Balance Center
Clarks Summit ● Tunkhannock
570-587-3277

Consent for Treatment, Payment & Healthcare Operations

I voluntarily give my permission to the health care providers of Abington Audiology and Balance Center and such assistants and other health care providers as they may deem necessary to provide services to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from , or until I withdraw my consent in writing.

I understand that all information shared with the clinicians at Abington Audiology and Balance Center is confidential and no information will be released without my consent. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.
C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I consent to the use or disclosure of my protected health information by Abington Audiology and Balance Center for the purpose of analyzing, diagnosing or providing treatment ot me, obtaining payment for my health care bills or to conduct health care operations of Practitioner. I understand that analysis, diagnosis or treatment of me by Practitioner may be conditioned upon my consent as evidenced by by my signature below.

If I have any questions regarding this consent form or about the services offered at Abington Audiology and Balance Center, I may discuss them with my clinician. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by Abington Audiology and Balance Center. I understand that I may stop treatment at any time.

Signature of Patient or Representative:_____Date_____