

**RONNY D. BAKER, B.S., A.C.A.**  
**Brazos Valley Hearing Services**  
**3608 E. 29<sup>TH</sup> St., Suite 113**  
**Bryan, TX 77802**  
**Ph. (979) 776-5875 / Fax (979) 260-9459**

**PATIENT INFORMATION FORM**

Patient ID: \_\_\_\_\_

1. Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Last Name) (First Name) (M.I.)

2. Social Security #: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Email: \_\_\_\_\_

3. Phone Numbers: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Home) (Cell) (Work)

4. Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

6. Primary Care Physician: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

7. Do you have health insurance that covers hearing aids? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, which company? \_\_\_\_\_ Ph. \_\_\_\_\_

8. Do you currently wear hearing aids? Yes \_\_\_\_\_ No \_\_\_\_\_; Brand: \_\_\_\_\_

9. How did you hear about us? \_\_\_\_\_ Specify? \_\_\_\_\_  
(Ex. newspaper, radio station, doctor, friend, internet) (Ex. The Eagle, Ch. 60, etc.)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**PATIENT ACKNOWLEDGEMENT AND RECEIPT OF:**

**NOTICE OF PRIVACY PRACTICES PURSUANT TO HIPAA AND CONSENT FOR USE OF HEALTH  
INFORMATION**

Name: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
**Print Patient's Name**

**The undersigned does hereby acknowledge that he or she has received a copy of this office's  
Notice of Privacy Practices Pursuant to HIPAA.**

**The undersigned does hereby consent to the use of his or her health information in a manner  
consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance  
Manual, State Law, and Federal Law.**

Dated today: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

By: \_\_\_\_\_  
**Patient's Signature**

**If patient is a minor or under a guardianship order as defined by State Law:**

By: \_\_\_\_\_  
**Patient's Guardian Signature**

## **NOTICE OF PRIVACY PRACTICES**

Effective August 7, 2015

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Ronny D. Baker, B.S., A.C.A. Privacy Officer at 979-260-9135.

### **OUR PLEDGE REGARDING MEDICAL INFORMATION**

Ronny D. Baker, B.S., A.C.A., as required by law, Health Insurance Portability and Accountability Act (HIPAA), pledges to maintain the privacy of your health information and to provide you with a notice of our legal duties and privacy practices.

### **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

Your protected health information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bill, to support the operation of Ronny D. Baker, B.S., A.C.A., and any other use required by law.

#### **Treatment**

We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, your protected health information may be provided to a physician whom you have been referred by Ronny D. Baker, B.S., A.C.A. to ensure that the physician has the necessary information to diagnosis and treat you.

#### **Payment**

Your protected health information will be used, as needed to obtain payment for your healthcare services. However, we will agree with any request you make regarding the restriction on the disclosure of your PHI to a health plan if the disclosure is for the purpose of payment and you have paid for the item or service out-of-pocket and in full.

#### **Healthcare Operations**

We may use or disclose, as-needed, your protected health information in order to support the business activities of Ronny D. Baker, B.S., A.C.A.. These activities include, but are not limited to, quality assessment activities, employee review activities, training, licensing, and conducting or arranging of other business activities. In addition, we may call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. However, we will agree with any request you make regarding the restriction on the disclosure of your PHI for healthcare operations.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity, National Security and Workers' Compensation.

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, authorization or opportunity to object unless required by law. Scanned and faxed signatures will suffice as the original. Uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI can be made only with your authorization.

### **YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION**

**Right to Inspect and Copy** You have the right to inspect and receive a copy of medical information that may be used to make decisions about your care. This includes medical and billing records, but does not include psychotherapy notes. To inspect or receive a copy of your medical information, you must submit your request in writing to Ronny D. Baker, B.S., A.C.A.. You may be charged reasonable administrative fees.

**Right to Amend** If you feel that medical information we have about you is incorrect you may ask to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, your request must be made in writing and submitted to Ronny D. Baker, B.S., A.C.A.. You must provide a reason that supports your request.

**We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:**

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by Ronny D. Baker, B.S., A.C.A.;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

**Right to an Accounting of Disclosures** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made for purposes other than treatment, payment, or healthcare operations or pursuant to your authorization. To request this list or accounting of disclosures, you must submit your request in writing to Ronny D. Baker, B.S., A.C.A.. Your request must state a time period that may not be longer than six years and may not include dates before March 2, 2015. You have the right to be notified when a breach of your unsecured PHI has occurred.

**Right to Request Restrictions** You have the right to request a restriction or limitation on the medical information we use or disclose about you. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member, friend or other responsible party.

***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

**Right to Request Confidential Communications** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you must make your request in writing to Ronny D. Baker, B.S., A.C.A.. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Right to a Paper Copy of This Notice** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

**Right to Opt Out of Communications** You have the right to opt out of any or all fundraising communications we may send to you regarding products available to you as a patient of Ronny D. Baker, B.S., A.C.A..

## **CHANGES TO THIS NOTICE**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice. The notice will contain the effective date. In addition, each time you receive treatment or healthcare services we will make a copy of the current notice available to you.

## **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with Ronny D. Baker, B.S., A.C.A. or with the Department of Health and Human Services. You Will Not Be Penalized For Filing A Complaint. All complaints must be submitted in writing to:

Ronny D. Baker, B.S., A.C.A.  
Privacy Officer  
3608 E. 29<sup>th</sup> St. Ste. 113  
Bryan, TX 77802