Quiet Corner Hearing Aids

Elyse Kirschblum, M.A. | **Sara Witek, Au.D, CCC-A**
145 Pomfret St. Rte. 44 Second Floor, Putnam, CT 06260| Phone: 860-481-3063 | Text: 860-792-5482 | Email: quietcorner@entassoc.com

Last Name:_____ **First Name**:_____

Sex: F /M /Prefer not to answer **Date of Birth**:_____ SS#_____-____-_____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code**:_____

☐ **Home Phone**: _____ ☐ **Cell Phone**: _____

E-Mail: _____

Please circle preferred method of communication:

Call **Text** **Email**

Ethnicity: Hispanic/ Latino **or** Not Hispanic/Latino **Race**: _____ **Language:** _____

Marital Status: _____ **Occupation**: Full Time / Part Time / Not Employed / Retired / Disabled /Other

Emergency Contact:
Name:_____ Relationship:_____ Phone: _____

Insurance Name: _____

Primary Insurance Subscriber: **Self:** ☐

Last Name:_____ First Name:_____
Date of Birth:_____ Phone:_____ Relationship:_____
Address:_____

Turn Over for Page 2

Quiet Corner Hearing Aids

Elyse Kirschblum, M.A. | **Sara Witek, Au.D, CCC-A**
145 Pomfret St. Rte. 44 Second Floor, Putnam, CT 06260| Phone: 860-481-3063 | Text: 860-792-5482 | Email: quietcorner@entassoc.com

NO SHOW POLICY & APPOINTMENT POLICY

At Quiet Corner Hearing Aids, we are committed to providing timely, high-quality care to all patients. Keeping scheduled appointments allows us to serve you and others effectively. Patients who miss their scheduled appointments without prior notice will be charged a no-show fee and will not be able to reschedule until the outstanding no-show balance is paid. If you are unable to attend your appointment, please contact the office in advance to cancel or reschedule.

Cancellations & Rescheduling
If you need to cancel or reschedule an appointment, please notify our office at least 24 hours in advance.
Missed Appointments (No-Shows)
A missed appointment occurs when a patient does not arrive for a scheduled visit and does not provide advance notice.

Missed Appointment Fees:

- **$100.00 fee charged for no show consultation appointments.**
- **$125.00 fee charged for no show consultation with hearing test appointments.**
- **$100.00 fee charged for no show fitting appointments.**
- **$100.00 fee charged for Adoption of Care appointments.**
- **$35.00 fee charged for no show hearing aid checks (all types)/ear mold appointments.**
- **$55.00 fee charged for no show hearing aid checks (all types) with hearing test appointments.**

Appointment Reminders
We provide reminders via phone, text, or email. Please keep your contact information up to date.
Repeated Missed Appointments
Repeated missed visits may result in changes to scheduling or transfer of care in accordance with regulations.
Acknowledgment
By scheduling an appointment, you acknowledge this policy.

Patient Signature: _____ Date: _____

Relationship to patient if signing for patient:

_____

5/28/2026

Quiet Corner Hearing Aids

Elyse Kirschblum, M.A. | **Sara Witek, Au.D, CCC-A**
145 Pomfret St. Rte. 44 Second Floor, Putnam, CT 06260| Phone: 860-481-3063 | Text: 860-792-5482 | Email: quietcorner@entassoc.com

HIPAA NOTICE OF PRIVACY PRACTICES & CONFIDENTIAL COMMUNICATION

Patient Name: _____ Date of Birth: _____

CONFIDENTIAL COMMUNICATION REQUEST
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have the right to request that we communicate with you about your health information in a specific way or at a specific location.
May we speak with someone other than you about your medical information?

YES or NO If YES, please complete below:

Name: _____
Relationship: _____
Phone: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
I understand that my protected health information may be used and disclosed for:
• Treatment, including coordination among healthcare providers
• Payment for services
• Healthcare operations such as quality review and administrative activities
I understand:
• I may request restrictions on certain uses and disclosures (in writing).
• If I pay in full out-of-pocket, I may request that information about that service not be sent to my insurance.
• Certain disclosures (such as psychotherapy notes or marketing use) require my written authorization.
• I will be notified in writing if a breach of my protected health information occurs.
• I may request a full copy of the complete Notice of Privacy Practices at any time.

Signature: _____ Date: _____

If signed by someone other than patient, relationship: _____

***Turn Over for Page 2**

Elyse Kirschblum, M.A. | **Sara Witek, Au.D, CCC-A**
145 Pomfret St. Rte. 44 Second Floor, Putnam, CT 06260| Phone: 860-481-3063 | Text: 860-792-5482 | Email: quietcorner@entassoc.com

Quiet Corner Hearing Aids

CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO)

I. CONSENT TO TREATMENT

1. I give my permission to be treated. This may include examinations, tests and procedures, medical treatment and admission to facilities under the care of a doctor and/or care provider, which they or their authorized agent may think is necessary or the best course of action. I understand specific consent forms may need to be signed for specific procedures. If I have a religious objection to specific care to be provided, I may ask not to provide that care.
2. I understand and agree that my care may include taking photographs/video and making sound recordings that may be used for my care and/or for education, as well as health care operations purposes.
3. I understand and agree that others, under the direction of a doctor and/or care provider, may help with or take part in giving hospital and/or medical care to me. These may include doctors and/or care providers in training and medical/nursing students.
4. I give permission to properly dispose of any specimens/tissue taken from my body. I understand specimens/tissue may be used for educational or research purposes in accordance with state and federal law.
5. I understand that no guarantees have been made about the outcome or results of any examination or treatment, and I understand that I have the right to refuse treatment at any time.
6. I understand and agree that care or services may be provided through telehealth. The provider will decide whether the condition being diagnosed or treated can be properly managed through telehealth.
7. I authorize and consent to communicate by phone, email and/or text.

II. FINANCIAL ARRANGEMENTS

1. I also understand and agree that, to the extent permitted by my insurance or coverage, I am financially responsible for all charges, co-payments and deductibles remaining after insurance payments, and all Quiet Corner Hearing Aid charges that are not covered by my insurance or third-party payers.
2. I assign benefits and insurance proceeds to Quiet Corner Hearing Aids for services provided.
3. **Medicare Patient Certification and Assignment of Benefit:** I certify that any information I provide in applying for benefit under Title XVIII (“Medicare”) or Title XIX (“Medicaid”) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Quiet Corner Hearing Aids by the Medicare or Medicaid program.
4. I acknowledge that I have received, read, and understand the Practice’s Appointment and No-Show Policy. I agree to comply with the policy, including providing required notice for cancellations or rescheduling. I understand that failure to provide adequate notice or failure to attend a scheduled appointment may result in a no-show or late cancellation fee, for which I am financially responsible.

III. PATIENT VALUABLES

I release Quiet Corner Hearing Aids from responsibility for loss or damage to personal property I choose to keep with me.

IV. AGREEMENT THAT ANY LEGAL ACTION WILL BE FILED IN A COUNTY IN WHICH CARE IS PROVIDED

I understand and agree that any legal action related to my care must be filed in the county where care was provided.

ACKNOWLEDGMENT

I have read this Authorization/Consent for Treatment, Payment and Health Care Operations (TPO) form or have had it read to me and it has been explained to my satisfaction.

Patient Signature: _____ Date: _____

5/28/2026