



- Enrolling your practice in Connect Care is easy and free. You choose which mailing services you'd like to utilize and how you'd like to enroll your patients, ESCO will do the rest.
- As business associates, your practice and ESCO share this patient information within HIPAA regulations and guidelines, per PL 104-191.
- ESCO will not mail or solicit your patients for anything that you have not authorized.
- By signing this form, you authorize ESCO to inform your patients when their warranty is about to expire and offer applicable ESCO coverage.

## Practitioner Information

Office Name: \_\_\_\_\_

Office Contact Person/Title: \_\_\_\_\_

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

City, State, Zip: \_\_\_\_\_

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

Email: \_\_\_\_\_ Web: \_\_\_\_\_

Best time to reach me: \_\_\_\_\_

## Type of Office

Private Practice  ENT Clinic  Non-Profit  Other \_\_\_\_\_

## What office management software are you currently using?

Sycle.Net  Tims  Blueprint  Hearform  Other \_\_\_\_\_

## Which mailing services would you like ESCO to provide your practice?

Reminder Care Cover Letter  Annual Care Contact  
 Patient Care Survey  Birthday Letter

## When will you submit your patient information?

Conclusion of Trial Period  Weekly  Monthly  Other \_\_\_\_\_

## How will you submit your patient information?

Online  Spreadsheet  Individual Postcards  
 Fax Sheets  Export via software management software

## Agreement:

I would like ESCO to notify my patients before the expiration of their manufacturer's warranty, with an offer of ESCO coverage.

I agree to provide essential information regarding my patients hearing instruments and their original manufacturer's warranty with a minimum of 10 patient names per month.

In addition to the warranty expiration notices, ESCO agrees to print and mail only the selected mail services above. ESCO reserves the right to discontinue this offer at any time.



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\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Practitioner Printed Name

\_\_\_\_\_  
ESCO Signature