familyaudiology
...we're listening.

Patient Information

Patient _____ SS# _____
Address _____ DOB _____
City, State, Zip _____ Cell# _____
E-Mail _____ Home# _____
Marital Status: Married Single Divorced Widowed

Whom may we thank for referring you to our office? _____

I authorize Family Audiology to release my hearing healthcare records to: (include names)

- O Family Physician _____ Location or Phone # _____
- O School _____
- O Other (spouse, son, etc.)_____

Primary Insurance Company _____ ID or SS# _____
Name of Policy Holder _____ Relationship to patient _____
Date of birth _____ status: employed retired unemployed student Employer _____

Secondary Insurance company _____ ID or SS# _____
Name of Policy Holder _____ Relationship to patient _____
Date of birth _____ status: employed retired unemployed student Employer _____

We may accept assignment of insurance benefits. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 90 days, the balance will be automatically billed to you. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary to medical insurance.

Our practice is committed to providing the best service for our patients/clients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

I have read and understand the insurance policy. Initials _____

Protected Health Information (PHI)
I authorize Family Audiology to contact me regarding my PHI via mail, phone message and e-mail. Initials ____

In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician and/or the provider, if any, who referred me here.

I understand and agree that full payment is due at time of service. Regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Family Audiology of any changes in my health status or in the above information.

I have reviewed this office's Notice of Privacy Practices that explains how my health information will be used and disclosed. I understand that I am entitled to a copy of this document.

I have read and agree to all of the above.

Signature_____ Date: _____

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