



**MOUNTAIN AUDIOLOGY, INC.**  
61 HAYWOOD PARK DRIVE, SUITE B  
CLYDE, NORTH CAROLINA 28721

**CONFIDENTIAL**  
PHONE: (828) 627-1950 Toll Free: (866) 601-1950  
FAX: (828) 627-1070  
EMAIL: mtnaudio@bellsouth.net

### PATIENT INFORMATION

Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Full Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Physical Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Marital Status: ( ) Single ( ) Married ( ) Widowed ( ) Divorced Sex: ( ) Male ( ) Female  
Social Security Number \_\_\_\_\_ Email: \_\_\_\_\_  
Name of Employer \_\_\_\_\_  
Phone of Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Spouse or Parents name \_\_\_\_\_  
Spouse or Parent Work Place \_\_\_\_\_ Phone \_\_\_\_\_  
In case of emergency contact (other than your residence) \_\_\_\_\_  
Phone Number: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Relationship: \_\_\_\_\_

### RESPONSIBLE PARTY INFORMATION

*(If patient is under the age of 18, the parent or guardian who brings the child is deemed the responsible party.)*

Person responsible for this account \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Address \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Employer \_\_\_\_\_  
Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

### Family Physician

Address \_\_\_\_\_ Phone \_\_\_\_\_

**Referral Source:** (Please circle the most appropriate source)

Physician \_\_\_\_\_ Friend (Please List their Name) \_\_\_\_\_

Yellow Pages \_\_\_\_\_ Advertisement \_\_\_\_\_ Hospital \_\_\_\_\_ Website \_\_\_\_\_ Internet \_\_\_\_\_ Facebook \_\_\_\_\_

Family Member (Please List their Name) \_\_\_\_\_ Other \_\_\_\_\_

### INSURANCE INFORMATION

*(Please allow the receptionist to make a copy of your insurance cards and a photo ID for the record)*

Primary Insurance Company \_\_\_\_\_ Policy Holder \_\_\_\_\_  
ID or policy number \_\_\_\_\_ Policy Holder Date of Birth \_\_\_\_\_  
Second Insurance Company \_\_\_\_\_ Policy Holder \_\_\_\_\_  
ID or policy number \_\_\_\_\_ Policy Holder Date of Birth \_\_\_\_\_

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**AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES:** It is the policy of our practice not to release Protected Health Information (PHI) pertaining to your medical care by phone or electronic device without prior permission. When returning or making calls to an electronic device (i.e. answering machine), we will not leave a message if the recorded greeting does not identify your residence. Information will not be shared with any unauthorized person who may answer your telephone. If you would like to have your medical information released to someone other than yourself, please complete the authorization below. I authorize Mountain Audiology, Inc. to release any and all such PHI to the following persons and will notify the practice of any changes to this consent:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

I authorize Mountain Audiology, Inc., and its agents to leave PHI by the following methods and will assume complete responsibility to notify them whenever this authorization or any of my contact information changes:

**PLEASE CIRCLE:**

**Home Telephone / Home Telephone Answering Machine / Work Telephone Voice Mail**  
**Mail to Home Address / Cellular Phone / Cellular Phone Voice Mail / E-MAIL**

When my PHI is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke or change this authorization in writing except to the extent that Mountain Audiology, Inc. has acted in reliance upon this authorization. My written revocation, or changes, must be submitted to the practice Privacy Officer.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I certify that the information given by me above is correct. I hereby assign, transfer, and set over to Mountain Audiology, Inc., all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy or policies as listed above. I authorize the release of any medical or incidental information that may be necessary in processing applications related to these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges that are not covered by my insurance.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**IF YOU HAVE MEDICARE INSURANCE PLEASE BRING A COMPLETE LIST OF MEDICATIONS**