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