North Carolina Audiology Associates
Cynthia A. Schaffer, Au.D.

Date ____________________

Patient Information

Name____
(last) (first) (M.I.)

Address ____
(Street) (City) (State) (Zip Code)

Phone ____
(Home) (Work) (Mobile)

Date of Birth ___________________ Sex ____ M ____ F Status: ____Single ____Married ____Other

Primary Physician _____________________________ Who Referred you to our office? ___________________

I **authorize that** North Carolina Audiology may leave messages on voice mail at the following numbers:

_____**Home** number ______**Work** number ______**Mobile** number ______ **NONE**

I **authorize** North Carolina Audiology Associates to verbally release any or all information concerning my medical care to the following individuals.

Name	Relationship to Patient	Telephone Number
Name	Relationship to Patient	Telephone Number
Name	Relationship to Patient	Telephone Number

NOBODY _______

Primary Insurance Information: Insurance Company ____

Insured Name __________________________DOB: ___________ Relation to Patient __________________

Additional Insurance Information: Insurance Company _______________________________________

Insured Name __________________________DOB: ___________ Relation to Patient __________________

Assignment of Benefits

I hereby authorize payment directly to North Carolina Audiology Associates of all insurance benefits payable for the services rendered. I understand that I am financially responsible for all charges, whether or not they are paid by insurance, for all services rendered on my behalf or my dependents.

Signed ____ Date ________________________________

Receipt of Privacy Notice

I attest that I have received the Privacy Notice from North Carolina Audiology Associates, Ltd. I understand that the delivery of my healthcare services will in no way be conditioned upon my signature in this section.

Signed ____ Date ________________________________