HEARING Solutions

Patient Intake Form

Name		Date of Birth	Gender
Street Address	City	State	Zip
Home Phone	Cell Phone		
Email Address		Marital Status	
Physician	How did you hear about us?		
Emergency Contact Name	Phone Number	Relationship	
Employer Name		*Circle One*: Currently Employed or Retired	
Insurance			

In order for us to file an insurance claim for you, the following must be signed:

I authorize the release of any medical and/or other information necessary to process my medical claim. I also request that payment of the government benefits, either to myself or to the party who accepts assignment. Further, I authorize payment of medical benefits to be made directly to Hearing Solutions, LLC for services rendered and understand that I am ultimately responsible for any balance due. This authorization shall remain in effect until otherwise stated, in writing, by myself.

Patient's Signature:_____Date:_____

HIPAA Acknowledgement

I understand that, under the Health Insurance Portability & and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received a copy of Hearing Solutions Notice of Privacy Practices and have been given the opportunity to review it. I have also been made aware there is a copy of Hearing Solutions Privacy Practices with a more complete description of the uses and disclosures of my health information available to me upon my request.

May we leave a message on your answering machine regarding your hearing health? Yes____No____

May we send you mail in regards to warranty expirations, special promotions, etc? Yes____No____

May we discuss your hearing health with a family member? Yes____No____

Patient's Signature:_____Date:_____