4130 Abrams Road
Dallas, TX 75214
(214) 827-1900

10611 Garland Road, Suite106
Dallas, TX 75218
(214) 660-9888

7615 Campbell Road, Suite 109
Dallas, TX 75248
(972) 380-0222

5462 Glen Lakes Drive
Dallas, TX 75231
(214) 987-4114

Patient Information

Name:_____ Date of Birth: _____

Address:_____ Gender: M F

_____ Marital Status: _____

Home Phone:_____Cell Phone:_____ Work Phone: _____

Other Phone:_____Email: _____

The best way to contact you? (please circle) home phone cell phone work phone email other _____

Primary PHYSICIAN Name:_____Address/Phone: _____

Employer:_____Status: Retired Full-Time Part-Time Student

How did you HEAR ABOUT US?: _____

IN CASE OF EMERGENCY Contact: _____ Relationship: _____Phone: _____

Please INITIAL NEXT TO ALL STATEMENTS to indicate that you have read and understood them.

_____I authorize Total Hearing Care to provide services**.**

_____Our practice is dedicated to maintaining the PRIVACY OF YOUR HEALTH INFORMATION. We are required by law to maintain the confidentiality of your health information and will only disclose information in compliance with the Health Portability and Accountability Act of 1996 (HIPAA), as revised in the 2013 Omnibus modifications. You are entitled to receive a copy of the Notice of Privacy Practices and may ask us to give you a copy of this Notice at any time. I hereby acknowledge that I understand the Total Hearing Care Notice of Privacy Practices.

_____I am financially responsible for all services at the time rendered unless other arrangements are made in advance.

_____I would like a REPORT SENT TO THE PHYSICIAN named above or to the following physician, and I authorize the release of those records: Yes No

Physician's Name:_____Physician's Address: _____

INITIAL ONLY IF FILING INSURANCE:

_____Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims or accept responsibility for negotiating claims with your insurance company. As a courtesy, we will be happy to help you determine your coverage for our services and submit claims to your insurance company.

_____I hereby assign all medical benefits, including major medical benefits to which I am entitled, to Total Hearing Care. I permit a copy of this authorization to be used in place of the original.

_____I am financially responsible for all charges if not paid by my insurance. I hereby authorize Total Hearing Care to file my insurance and release all information necessary to secure payment. You must pay any co-payment, co-insurance, and applicable deductible amounts at the time of service unless other arrangements have been made. If insurance pays only a portion of the bill or fails to make payment to Total Hearing Care within 90 days, I WILL BE RESPONSIBLE FOR PAYMENT OF THE BALANCE IN FULL AT THAT TIME.

_____ _____

Signature Date

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Authorization for Use and Disclosure of Health Information

I request and authorize Total Hearing Care to disclose my protected health information as described below: (choose one)

_____I **consent** to Total Hearing Care releasing protected health information to those listed below.

_____I **prohibit** Total Hearing Care from using and disclosing medical information to any person or entity other than required by HIPAA regulations.

My protected health information may be used, discussed, or disclosed to the following (family member names, friends' names, etc; Information can automatically be discussed with a Power of Attorney or parent/guardian of a child under the age of 18):

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Expiration/Revocation

Expiration: This authorization will expire on (must choose one):

_____One year from the date it is signed

_____Other (insert date to expire or event, i.e. death):

_____No expiration date

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the top of this form. I understand that revocation of this authorization will not affect any action the above-named entity took in reliance on this authorization before the above named entity received my written notice of revocation.

_____ _____

Printed name of patient or personal representative Date

_____ _____

Signature of patient or personal representative Date