

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 _____

