Hearing HealthCare, Inc **Today's Date:_____/_____/_____**

PATIENT INFORMATION:

Name: First_____Middle_____Last_____

Gender: (please circle) Male Female Gender-Neutral

Address: _____Apt #___ **City**:_____

State:_____ **Zip Code**:_____ **Date of Birth**: _____/_____/_____

Home Phone:** ( )_____Work Phone:**( )_____

***Cell Phone**: ( )_____ ***Email Address**:_____

***Best phone contact number:** Home Work Cell

May we leave a message**?** Yes No May we email you? Yes No May we text you? Yes No

PRIMARY CARE PHYSICIAN NAME: _____

Who should we send results to?_____

REFERRAL SOURCE: (provide referral source name if applicable or circle source)

Physician Name:_____Phone:_____

Friend or Family Member Name:_____

Newspaper Internet Newsletter Website Mailing Other_____

PERSON RESPONSIBLE FOR BILLING:

Responsible Person's Name:_____

Address (if different from patient): _____

Relationship to Patient: _____ Phone: ( )_____

Employer (if applicable) _____

Insurance Policy Holder's Name:_____

Insurance Policy Holder's Date of Birth:_____

TRICARE PATIENT'S ONLY: MEDICAL DOD #_____

EMERGENCY CONTACT:

Emergency Contact Name: _____

Relationship to Patient: _____ Emergency Contact Phone: _____

***If patient is a minor, please fill out phone/email information of responsible person.**

Hearing HealthCare, Inc **Today's Date:_____/_____/_____**

NOTICE OF PRIVACY PRACTICES AND POLICIES

I give permission to Hearing HealthCare, Inc. to release my protected health information (PHI), verbal and written, contained in my medical record to my health insurance company in order to submit claims, related healthcare providers, and Hearing HealthCare's business associates when required to complete my care. All other requests for information must be submitted in writing to Hearing HealthCare, Inc., by the patient or assignees.

I authorize Hearing HealthCare, Inc. to release my personal health information (e.g. contact information) for third party marketing related to hearing care products or services. I understand that Hearing HealthCare, Inc. or its marketing partners may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described.

[ ] CHECK HERE if you do NOT want to receive third party marketing regarding hearing care, products or services, including our newsletter.

I have been informed of and have available to me, Hearing HealthCare, Inc.'s complete Notice of Privacy Policy pursuant to HIPAA. The Notice provides information about how we may use and disclose the medical information that we maintain about you, and we encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website and that any revised Notice of Privacy Practices will be made available. I understand that I am entitled to receive a copy of the Notice of Privacy Practices at any time.

I acknowledge and agree that regardless of my health insurance status, I am ultimately responsible for the balance of my account for professional services rendered and/or purchases made. I also acknowledge and agree that if any balance on my account remains unpaid after attempts have been made to collect, my account may be sent to a collection agency and incur additional fees.

I have read all the information on this sheet and have completed the above answers, certify this information is true and correct to the best of my knowledge and hereby give Hearing HealthCare, Inc. permission to treat my concerns.

_____ Date: _____/_____ /_____

Patient Signature or Parent/Guardian if Patient is a Minor

_____

Print Name