Patient Name:_____
(First) (Middle) (Last) (Preferred Name)

Gender: ☐Male ☐Female Birthdate: _____ Age:_____

Address:_____
(Street) (City) (State) (Zip)

Parent/Guardian if patient is a minor: _____ Relationship:_____

Cell Phone: _____ Email Address: _____

Permission to: LEAVE A VOICEMAIL? Yes / No TEXT? Yes / No EMAIL? Yes / No

Pediatrician or Primary Care Physician: _____

How did you hear about us? ☐ Doctor ☐ Facebook ☐ Google Search ☐ Our Website
☐ Insurance ☐ Friend/Relative ☐ Other

OUR FINANCIAL POLICY: Please present a copy of your insurance card at the time of your visit.
IF YOU DO NOT HAVE YOUR INSURANCE CARD, YOUR VISIT WILL BE RESCHEDULED.
All office co-pays are to be paid at the time of service. Non covered services are your responsibility. I have read and I agree to this financial policy.

Signature: _____ Date: _____

HIPAA -- Authorization for Release of Protected Health Information

I hereby authorize Augusta Hearing and Balance to share personal Health/Medical information that is protected by the Health Insurance Portability and Accountability Act (HIPAA) privacy rule. I give my permission to share any and all medical information with any medical provider, insurance company or other party that is involved in either the treatment or payment of services. I have the authority to give this permission described above and I am doing so voluntarily. I have received, read and understand your Notice of Privacy Practices.

I give permission for Augusta Hearing and Balance to request records from my physician to assist in my treatment.

Signature: _____ Date: _____

**This authorization can be revoked at any time by contacting Augusta Hearing and Balance in writing; information already shared cannot be recalled. I may ask for a copy of this signed form, as well as a copy of any my records.*

ENTERED ON: / /
BY: