Today's Date: _____

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

Gender: □Male □Female Age:_____ Birthdate: _____

Address:_____

City:_____ State:_____ Zip:_____

If Minor, Guardian Name:_____ Relationship:_____

Cell: _____ Work: _____ Home: _____

Email Address: _____

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

Pediatrician or Primary Care Physician: _____

How did you hear about us? _____

INSURANCE:

As a professional courtesy, we will submit your claim to your insurance provider, but this does not guarantee their payment. You accept responsibility for any co-pays, deductibles, or uncovered services, including hearing aids. You are also responsible for having the appropriate referral if required.

I understand that I am financially responsible for any charges incurred and understand that any insurance benefits paid will be credited to my account in accordance with the above assignment. I agree and understand to pay for any outstanding balances as stated above.

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD. Payment at the time of services will be required without a copy of this card.

_____ _____
Signature Date

Please see back page.

HIPPA -- Authorization for Release of Protected Health Information

I hereby authorize Augusta Haring and Balance to share personal Health/Medical information that is protected by the Health Insurance Portability and accountability Act (HIPPA) 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.

Patient Name: _____

_____ _____

Signature Date

*If there is anyone you do not wish to have your information shared with, please list below:

_____

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.