STONE AUDIOLOGY

PATIENT INFORMATION FORM

PATIENT NAME: (Last) _____ (First) _____ (Middle Initial) _____

ADDRESS: _____
(Street) (City, State, Zip Code)

TELEPHONE NUMBER: _____ _____
(Home) (Cell/Work)

E-MAIL _____ DATE OF BIRTH_____

RESPONSIBLE PARTY NAME: _____

PATIENT RELATIONSHIP TO PARTY: □ SELF □ CHILD □ PARENT □ SPOUSE □ EMPLOYEE

PRIMARY PHYSICIAN NAME: _____

PHYSICIAN ADDRESS: _____
(Street) (City, State, Zip Code)

PHYSICIAN TELEPHONE: _____ _____
(Office) (Fax)

EMERGENCY CONTACT: _____ _____
(Name) (Phone)

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1. Are you a previous patient: □ Yes □ No
   If yes, which office? _____

How did you hear about *STONE AUDIOLOGY ?* _____

2. Is this visit covered by a Health Insurance Plan? □ Yes □ No
   If yes, please present you member identification card and/or referral if applicable.

3. Is this visit covered by any other payors?
   (Example: Workers' Compensation, a secondary health insurance plan, a family member's insurance plane, your employer, etc.) If yes, please present your member identification card and/or referral if applicable.

CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, you are granting consent to *Stone Audiology* to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. You have the right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

_____ _____
Signature Date