Hearing Associates of Florence
1901 Hwy. 101, Suite A
Florence, Oregon 97439
Phone: 541-997-7617
Fax: 541-997-3962
www.hearingassociatesofflorence.com

Patient Name:	**Sex:**
Address:	
City/State/Zip:	
Primary Phone #:	**Secondary Phone #:**
Birth Date:	**Age:**
Email:	
Emergency contact:	**Relationship:**
Emergency contact phone number:	
Primary Care Dr.:	

May we leave a message on your voicemail or answering machine? ___ Yes ___ No

May we leave a message with anyone who answers the phone numbers provided? ___ Yes ___ No

May we contact you via e-mail? ___ Yes ___ No

May we contact you via text? ___ Yes ___ No

(This insurance section may be left blank, if the patient is the primary card holder.)

Primary Insurance:	**ID no.:**
Person responsible for insurance:	
Relationship to Patient:	**Birthdate:**
Address(if different from patient's):	

Secondary Insurance:	**ID no.:**
Person responsible for insurance:	
Relationship to Patient:	**Birthdate:**
Address(if different from patient's):	

Reason for appointment:

_____

_____

How did you hear about us? (If you are an existing patient, you may skip this section)

___ Referred by Physician (Name: _____)
___ Internet search
___ Website
___ Referred by Friend/Family (Name:_____)
___ Yellow pages
___ Other _____

Privacy Policy (Please read carefully and sign below)

I give permission to Audiology Consultants of Southern Oregon, Inc(ACSO), dba Roseburg Audiology Center and Hearing Associates of Florence to:

- release information, verbal and written(contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, employer, related health care providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.
- use and release my protected health information, i.e., my contact information, for marketing related to hearing care products or services offered by ACSO. ACSO does not sell your protected health information to third parties.
- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.
- I have read and verified all of the information on this sheet, and certify this information is true and correct to the best of my knowledge, and I hereby give my hearing care provider permission to treat my concerns.

I have read and understand all the above information.

_____ _____
Patient Signature (A copy of this signature is as valid as the original) Date

_____ _____
Signature of Parent or Guardian Date