# *The Americans for Better Hearing Foundation*

## *Patient Intake Form*

Name:_____ Date of Birth: ____/____/____
First MI Last

Address:_____
Street Apt # City State Zip

Home Telephone:_____ Cell:_____

Email: _____ Occupation: Employed Unemployed Retired Student

Marital Status: Single Married Divorced Widowed

Do you live in a Nursing Facility: ___Yes ___ No

If you live in a facility is it: *(Please circle one):* Supportive Living Assistive Living Nursing Facility

If so what is the name of the facility: _____

Emergency Contact: _____ Relationship:_____

Telephone Number:_____

Primary care physician: _____Phone:_____

### Who referred you to our office?

We like to know how our patients find our practice. If your physician, a family member, or a friend sent you in, we want to thank them. If you learned about our office another way, it is helpful that we know. Please check below:

Family/Friend Name: _____ Insurance Company _____

Physician/Audiologist Name: _____ Other: _____

### ASSIGNMENT OF BENEFITS

1.) I authorize the release of any medical and/or other information necessary to process my medical claim. I also request that payment of government benefits, either to myself or to the party who accepts assignment.
2.) Further, I authorize payment of medical benefits to be made directly to ABHF for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

### RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize ABHF to release any and all medical information in the course of my (or my child's) treatment to the primary care physician or any other physician that me (or my child) is under the care of besides my primary care physician.

### NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of the **Notice of Privacy Practices** being adhered to by ABHF/CHS. The notice of Privacy Practices is supplied in accordance with the Privacy rule that is an integral part of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

X_____ _____/____/____
Patient/Parent/Guardian Signature Date