Harbor Audiology

100 Madrid Blvd, Suite 214
Punta Gorda, FL 33950
Phone: (941) 505-0400
Fax: (941) 505-0022

WELCOME TO HARBOR AUDIOLOGY, PA

Today's Date: _____

Patient's Name: _____ Title: _____.
Last First MI

Address: _____

City: _____ State: _____ Zip: _____ E-Mail: _____

Phone: (H) _____ (W) _____ (C) _____

Social Security # _____ Date of Birth: _____ Age: _____ [

Referring Doctor: _____ Primary Care Physician: _____

How did you hear about us? _____

Physician Hearing aid Manufacturer Friend or Family member HIP Newspaper

Internet Saw a sign Yellow pages I am a previous patient Direct mail Radio or TV

How can we help today? _____

Hearing Exam Wax removal Evaluation for New Hearing Instruments Swim plugs Musician Earplugs

Hearing aid clean and check Hearing Aid Repair Replace earmold Hearing instrument adjustment

Assistive device for TV or telephone Tinnitus Evaluation

I understand I am responsible for payment of professional fees and equipment at the time of service. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefit payable to which I am entitled, including Medicare, private insurance and other health plans to Harbor Audiology, P.A. I understand I am financially responsible for any deductibles, co-insurance, or any other balance not paid by my insurance. If this account is assigned to an attorney or collection agency I am responsible for any collection fees or attorney fees involved in the collection of this claim.

I agree to the assignments and financial responsibilities outlined above.

X _____ Date _____
Signature

NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the Notice of Privacy Practices for Harbor Audiology, P.A.. With this consent, Harbor Audiology, P.A. may call my home or other location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and calls pertaining to my clinical care. With this consent, Harbor Audiology, P.A. may mail to my home or alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements.

In addition to the disclosure notice outlined in the Notice of Privacy Practice, I authorize Harbor Audiology, P.A. to disclose my individually identifiable health information to:

PHYSICIAN_____

FAMILY MEMBER:_____

FRIEND: _____

HEALTH CARE AID: _____

TRUST FUND, CPA or ATTORNEY_____

I may revoke this consent in writing at any time except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian

LIFE TIME AUTHORIZATION
MEDICARE/INSURANCE CERTIFICATION FOR PAYMENT

Insurance information:
Primary Insurance Co: _____ Insured's ID #_____

Policy holder name: _____ Policy holder DOB:_____

Relationship to patient: Self Spouse Parent Policy holder's SS #: _____

Policy Holder's Employer:_____

Secondary Insurance Co.: _____ Insured's ID#_____

Policy holder name: _____ Policy holder's DOB: _____

Relationship to patient: Self Spouse Parent Policy holder's SS #:_____

Policy holders Employer: _____

I certify that the information given in applying for payment under the title XVII of the SSA is correct. I authorize Harbor Audiology, PA,. to use this signature as a release to the Social Security Administration or its intermediaries or carriers, or to the billing agent of this practice, any information needed for this or a related Medicare claim. I request that the payment of benefits be made on my behalf. I permit a copy of this authorization be used in place of the original. I may revoke this authorization by notifying Harbor Audiology P.A. in writing.

I REQUEST THAT THIS AUTHORIZATION ALSO APPLY TO ALL OTHER INSURANCE.

Patient Name:_____ Date:_____

Patient Signature:_____

MEDIGAP (MEDICARE SUPPLEMENT INS) AUTHORIZATION

I request that payment of the authorized Medigap benefits be made on my behalf to:
Harbor Audiology, P.A.

For any services furnished me, I authorize any holder of medical information about me and/or information needed to determine these benefits or the benefit payable for related service to release it to my Medigap insurer or my secondary insurer.

Patient Signature: _____ Date: _____

If signed by other than the patient, state reason the patient was unable to sign:

Reason:_____