HEARING & BALANCE CENTER, P.C.

PATIENT INFORMATION

PATIENT FULL NAME		DATE OF BIRTH	
STREET ADDRESS		CITY	ZIP CODE
EMAIL ADDRESS	HOME PHONE	CELL PHONE	
EMPLOYER	WORK #	PREFERRED METHOD OF CONTACT (PLEASE CIRCLE) HOME CELL WORK	
GENDER (PLEASE CIRCLE) MALE FEMALE	MARITAL STATUS (PLEASE CIRCLE) MARRIED SINGLE DIVORCED WIDOWED LIFE PARTNER	PREFERRED LANGUAGE (PLEASE CIRCLE) ENGLISH SPANISH OTHER	

PATIENT INFORMATION (OPTIONAL)

ETHNICITY (PLEASE CIRCLE)	RACE (PLEASE CIRCLE) WHITE BLACK/AFRICAN AMERICAN
HISPANIC/LATINO NOT HISPANIC/LATINO UNKNOWN	AMERICAN INDIAN/ALASKAN NATIVE ASIAN OTHER

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME	POLICY ID #	GROUP #
POLICY HOLDER'S NAME (IF OTHER THAN PATIENT)	RELATIONSHIP TO POLICY HOLDER	POLICY HOLDER'S DATE OF BIRTH

SECONDAY INSURANCE INFORMATION

INSURANCE COMPANY NAME	POLICY ID #	GROUP #
POLICY HOLDER'S NAME (IF OTHER THAN PATIENT)	RELATIONSHIP TO POLICY HOLDER	POLICY HOLDER'S DATE OF BIRTH

EMERGENCY CONTACT & OTHER INFORMATION

EMERGENCY CONTACT NAME/RELATIONSHIP	HOME PHONE	WORK PHONE	CELL PHONE
ADDRESS	CITY, STATE, ZIP CODE		
REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN		

AUTHORIZATION TO RELEASE INFORMATION: I/we hereby authorize Hearing & Balance Center to release any information needed, including the diagnosis & records of any treatment/examination rendered to me or my dependents to secure payment of benefits.

CONSENT FOR TREATMENT: I/we hereby authorize Hearing & Balance Center to administer diagnostic & medical procedures as may be necessary for proper healthcare.

NOTICE OF PRIVACY PRACTICES: I/we have received the Notice of Privacy Practices.

OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment on all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, co-pay or any other balance not paid for me by my insurance company. I authorize insurance benefits to be paid directly to the provider. In addition to the principle amount owed, I agree to pay 33.33% of the unpaid balance as collection fees if my account is turned over to a collection agency. I understand I will be charged $25.00 for all appointments not cancelled within a 24 hour notice.

SIGNATURE:____ **DATE:**______________________

(Patient – over 18 years or responsible party)

Patient Name: ____Date of Birth: ________________

Acknowledgement of Receipt of Notice of Privacy Practices for Hearing & Balance Center, P.C.

Hearing & Balance Center, P.C. is concerned about the privacy of our patients' health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment and will use and disclose your protected health information for treatment, payment and health care operations when necessary.

I acknowledge that I have received or been given the opportunity to receive a copy of the Notice of Privacy Practices from Hearing & Balance Center, P.C.

✕____ ____________________

SIGNATURE **(Patient, Legal Guardian or Personal Representative)** **Date**

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Print Name and Relationship (if not Patient)

Authorization for Use and Disclosure of Personal Health Information for Hearing & Balance Center, P.C.

I hereby authorize Hearing & Balance Center, P.C. to call/leave messages with medical information pertaining to my care by the following methods and I will assume responsibility to notify them whenever this information changes:

Voice Mail/Answering Machine

_______________________________________ ☐ **Yes** ☐ **No**

Home telephone number

_______________________________________ ☐ **Yes** ☐ **No**

Cell telephone number

_______________________________________ ☐ **Yes** ☐ **No**

Work telephone number

I hereby authorize Hearing & Balance Center, P.C. to use and disclose my medical and financial information with the person(s) identified below. It is at my request that the specific information that may be used and disclosed to the person(s) listed below includes any and all of my personal health information in the records of the Practice that pertain to me.

Name	**Relationship**	**Contact Number**
Name	**Relationship**	**Contact Number**
Name	**Relationship**	**Contact Number**

✕____ ____________________

SIGNATURE **(Patient, Legal Guardian or Personal Representative)** **Date**

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Print Name and Relationship (if not Patient)