Patient Intake Form

Name			Date of Birth	Gender
Street Address		City	State	Zip
Home Phone	Cell Phone		☐ iPhone	☐ Android
Email Address			Marital Status	
Physician	How did you hear about us?			
Emergency Contact Name	Phone Number		Relationship	
Employer Name			☐ Currently Employed	☐ Retired
Insurance				

In order for us to file an insurance claim for you, the following must be signed:

I authorize the release of any medical and/or other information necessary to process my medical claim. I also request that payment of the government benefits, either to myself or to the party who accepts assignment. Further, I authorize payment of medical benefits to be made directly to Hearing Solutions, LLC for services rendered and understand that I am ultimately responsible for any balance due. This authorization shall remain in effect until otherwise stated, in writing, by myself.

Patient's Signature:____Date:________________

HIPAA Acknowledgement

I understand that, under the Health Insurance Portability & and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received a copy of Hearing Solutions Notice of Privacy Practices and have been given the opportunity to review it. I have also been made aware there is a copy of Hearing Solutions Privacy Practices with a more complete description of the uses and disclosures of my health information available to me upon my request.

May we leave a message on your answering machine regarding your hearing health? Yes____No____

May we send you mail in regards to warranty expirations, special promotions, etc? Yes____No____

May we discuss your hearing health with a family member? Yes____No____

Patient's Signature:____Date:________________