Today's Date_____/_____/_____
mm dd yyyy

Patient Name_____ DOB_____/_____/_____
mm dd yyyy

Mailing Address_____
Street City State Zip

Home Phone # _____ Cell Phone #_____Alt/Work Phone# _____

Email _____ SSN _____ Gender ○ M ○ F

Employment Status: ○ Full Time ○ Part Time ○ Retired ○ Self Employed ○ Not Employed ○ Disabled

Occupation _____ Employer _____ Primary Physician _____

Marital Status: ○Married ○ Single ○ Widowed ○ Divorced ○ Long-Term Commitment

Spouse Name _____ DOB_____/_____/_____

Spouse's SSN _____ Spouse's Employer/Occupation _____

How did you hear about us? _____

Primary Reason for Today's Visit_____

If patient is not the policy holder or is a minor, responsible party must complete this section.

Name of Responsible Party_____ DOB _____/_____/_____
mm dd yyyy

Relationship to Patient_____Responsible Party SSN _____

Contact #_____

Please read carefully and sign below.

- I acknowledge that I have reviewed, or I have been provided, the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where, and why my confidential health information may be used or shared. I acknowledge that HCP may use and share my confidential health information with others in order to treat me and in order to arrange for payment of my bill.
- I hereby authorize the following individual(s) to receive information regarding my medical condition(s) and related billing information:

  _____
- This is a training facility and I acknowledge that video recording devices are in use.
- 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. If this account is assigned to an attorney/agency for collection and/or suit, I, as the responsible party, agree to pay all cost of collection, including attorney fees, collection fees, and contingent fees to the collection agency of not less than 40% of the total collection amount. Such contingency fees will be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency.
- I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge and hereby give Hearing Care Partners permission to treat my concerns.

_____
Patient / Legal Guardian Signature Date