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 _____ Sex ○ 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, responsibility party must complete this section.

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

Relationship to Patient_____Responsible Party SSN _____

Contact #_____

Insurance Information and Privacy Policy

Please read carefully and sign below.

- I give permission to Hearing Care Partners to release information, verbal and written (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.
  _____ Initial to ***REFUSE*** permission to release records.
- I acknowledge that I may receive and review the Health Insurance Portability & Accountability Act (HIPAA) policy at this office.
- 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.

I have read and understand all the above information.

_____
Patient / Legal Guardian Signature Date