

20 NW Birch Street Coupeville, WA 98239

Pediatric Patient Information:

| Date | | | |
|--|--|----------------|---------------|
| Legal Name: | s | Suffix: |]Female □Male |
| Nickname | Birth date: (MM/DD/YYYY) _ | | Age: |
| Parent or Legal Guardian: | Relation to Patient: | | |
| Physical Address: | | | |
| Billing Address: | | | |
| Home Phone: | | | |
| Email: | | | |
| Consent to Participate in Electronic F | Health Correspondence: | | |
| Emergency Contact Person: | Relation | on to Patient: | |
| Address: | Contac | t Phone: | |
| Primary Care Physician: | Clinic: | | |
| Referred by: | ☐ Friend ☐ Newspaper ☐ Direct Mail Piece | | |
| Other: | | | |
| List all persons and/or Medical Facility | | | |
| | | | |
| Persons and/or Facilities NOT Permi | tted to access your Health Reco | rds: | |
| Reason for Visit: | | | |

Guarantor Information: (Person Responsible for the Bill – if different from patient)

| Name | : | Relationship to Patient: | | |
|--------------------|--|--------------------------------------|---|--|
| Addre | ss | City: | Zip: | |
| | | Payment Information: | | |
| | Private Pay | | | |
| | Primary Insurance: | Subscri | ber's Name: | |
| | Identification #: | Group # | Subscriber's DOB: | |
| | Secondary Insurance: | Subscri | ber's Name: | |
| | Identification #: | Group #: | Subscriber's DOB: | |
| | | Permission to Bill Insurance | e | |
| is prov | | | n may be revoked at any time if written requestibility for all denied or non-covered services. | |
| | <u>ACKNOWLEDGEM</u> | ENT OF RECEIPT OF NOTICE O | F PRIVACY PRACTICES | |
| Privacy treatme | y Practices describes the types of ent, payment of services, or in the | uses and disclosures of my protected | r Hearing Health Services, LLC. The Notice of health information that might occur in my rations. The Notice of Privacy Practices also at to my protected health information. | |
| Name | of Patient or Personal Representa | ative | | |
| Signat | ture of Patient or Personal Repres | sentative | | |
| Descri | ption of Personal Representative's | Authority | | |
| Date | | | | |

The Privacy Rule portion of the HIPAA regulations requires our practice to submit a copy of the Privacy Notice to each patient, both existing and new. If the patient refuses to sign this notice, this practice is not obligated to treat the patient.