# *Family Hearing Center*

Zeigler – Asby Audiology

Patient's Full Name: Mr. Ms. Mrs. Dr. Sister _____

Preferred Name: _____ ☐ Male ☐ Female

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Is it OK to leave a message? ☐ Yes ☐ No Email Address: _____

What is the best way to reach you? ☐ Home Phone ☐ Cell Phone ☐ Email ☐ Other: _____

Date of Birth: _____ Age: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Patient Guardian (if patient under age 21): _____ Relationship: _____

Accompanied by: _____ Relationship: _____

Employer: _____ Occupation: _____

Business Phone: (_____) _____ Is it OK to call at work? ☐ Yes ☐ No

Family Physician: _____ Physician Phone Number: (_____) _____

How did you hear about our practice? ☐ Physician ☐ Yellowbook ☐ Newspaper ☐ Website ☐ Google ☐ Facebook

☐ Family Member/Friend: _____ ☐ Other: _____

Please list persons (family members, doctors, etc.) with whom you give us permission to discuss your health information, send reports, and schedule future appointments: _____

_____

_____

List power of attorney's contact information (if applicable): _____

_____

Reason for today's appointment: _____

_____

Previous Evaluation/Results: _____

_____

# PATIENT RECORD OF DISCLOSURES

Federal Health Insurance Portability and Accountability Act

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (*PHI*). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

**I have received and reviewed the "Notice of Privacy Practices" by Family Hearing Center.**

_____ _____

Patient / Guarantor / Guardian / Power of Attorney / Relationship Signature Date

**Please carefully read the following consent information:**

I consent to audiometric testing which is necessary to determine the extent of my hearing impairment. I authorize the release of all medical records to the referring and family physician. I acknowledge full financial responsibility for services rendered by Family Hearing Center. I understand that payment of any non-covered service, co-pays, coinsurance and/or deductibles are due at the time of service. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment. I authorize and request that assignment of insurance payments be made directly to Family Hearing Center.

MEDICARE PATIENTS:
I request that payment of authorized Medicare benefits be made on my behalf to Family Hearing Center. For any service furnished to me by Family Hearing Center (providers), I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for the benefits payable for related service.

MEDIGAP:
I request that payment of authorized Medigap benefits be made either to me or on my behalf to Family Hearing Center – Zeigler - Asby Audiology for any services furnished to me by Family Hearing Center (providers). I authorize any holder of Medicare information about me to release to my insurance any information needed to determine these benefits payable for related services.

**I have read and fully understand the above consent for treatment, financial responsibility, release for medical information and insurance authorization.**

**I authorize Family Hearing Center to send me periodic information regarding my hearing care.**

_____ _____

Patient / Guarantor / Guardian / Power of Attorney / Relationship Signature Date

_____ _____

Patient / Guarantor / Guardian / Power of Attorney / Relationship Signature Date

_____ _____

Patient / Guarantor / Guardian / Power of Attorney / Relationship Signature Date

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