Raleigh Hearing & Tinnitus Center

PATIENT INFORMATION FORM

Patient Full Name: _____ Preferred Name: _____

DATE OF BIRTH _____ ☐M ☐F ☐O Marital Status: ☐ Single ☐Married ☐Divorced ☐Widowed

Address: _____

City: _____ State: _____ Zip: _____

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

Can we leave you a voicemail with medical information at your (check all that apply): ☐HOME ☐CELL ☐WORK

Email Address: _____

Current Employment: ☐Full-Time ☐Part-Time ☐Retired ☐Self-Employed ☐Unemployed ☐Student ☐Child under 18*

**If patient is under 18 years of age, by signing below I acknowledge that I am a parent or guardian with legal rights to authorize healthcare services*

Occupation (If retired, list prior occupation/type of work performed): _____

Name of Family Physician: _____ Phone: _____

*How did you hear about us? _____

Is it OK to send you periodic practice updates and occasional news via email? ☐YES ☐NO

Emergency Contact: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION: To assure your insurance benefits are maximized and protected, please provide the following information and provide your insurance card(s) and photo identification to the Front Desk. (We are required to make copies of your insurance cards.)

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company	_____	_____
	ID#_____Group#_____	ID#_____Group#_____
Is the Patient the Policyholder?	☐ YES ☐ NO	☐ YES ☐ NO
IF NO – COMPLETE THE FOLLOWING INFORMATION (POLICY HOLDER aka SUBSCRIBER or PRIMARY MEMBER)		
Who is the policy holder?	_____	_____
Birthdate	_____	_____
Relationship to Patient	☐ Spouse ☐ Parent ☐Other: _____	☐ Spouse ☐ Parent ☐Other: _____

If you do not have insurance or do not want your insurance billed, initial that you accept responsibility for all charges for services rendered due at time of service. A 20% cash discount will be applied if paid at time of service.

AUTHORIZATIONS & POLICY ACKNOWLEDGEMENTS: My signature below indicates the following:

- ☐ **Insurance Authorization:** I authorize Raleigh Hearing and Tinnitus Center to bill my health insurance company for covered benefits and authorize the use of my signature on all insurance submissions. I request payment of benefits be made on my behalf to Raleigh Hearing and Tinnitus Center for services furnished to me. I agree to promptly pay (within 30-days) any amounts my insurance indicates are my responsibility.
- ☐ **Medical Records Release:** I authorize release of all information necessary to secure payment of benefits. I also authorize the release of medical information to my referring physician and/or primary care provider. I authorize any holder of medical information about me to release to Raleigh Hearing and Tinnitus Center any information needed to determine benefits payable and/or to coordinate my care for related services.
- ☐ **Financial Policy:** I understand that Raleigh Hearing and Tinnitus Center will bill my insurance for services rendered. The Patient Payment Policy is on the following page. I understand I will receive a statement of my account and agree to pay any amounts owed within 30-days of receipt.
- ☐ **Appointment No Show Policy:** I understand that there is a $50 no-show fee for 2 missed appointments.
- ☐ **HIPAA Privacy Practices Acknowledgement of Receipt:** I acknowledge that I have been given the opportunity to read the NOTICE OF PRIVACY PRACTICES, a copy of which is available in the waiting area. I understand a copy of this notice will be made available to me at my request.

(X) _____ _____ _____

Signature (Parent/Guardian) Printed Name Date

OFFICE Verified ID Matches Patient Name & Insurance Card: _____

T2/2-24-21