Welcome to the Hearing Improvement Center, L.L.C.

Patient Information

Please use your legal name and please print.

Please fill out this form as complete as possible. If you have any questions or need assistance, please ask us.

First Name: _____ MI: _____ Last Name: _____ Gender: Male / Female

Address_____City:_____State_____Zip_____-_____

Date-of-Birth: _____/_____/_____ Marital Status: Married _____Single _____ Widow _____ Other _____

Home Phone: _____ Work: _____Cell: _____

E-Mail: _____

Employer: _____Address: _____City: _____State: _____Zip:_____

Primary Care Physician: _____ Referring Physician or Person: _____

Can we send a report to your PCP? Yes _____ No _____ Do you use tobacco? _____

Allergies: _____

Medications: (If you have a list, we will make a copy.) _____

_____

_____

Emergency contact person: _____Relationship: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Tel.: _____ Cell: _____Work: _____

PLEASE GIVE YOUR INSURANCE CARD(S) TO THE FRONT DESK

IN ORDER FOR THEM TO BE COPIED

RELEASE OF INFORMATION STATEMENT

I hereby authorize release of information to appropriate insurance company(ies) and referring doctors that I have requested above.
I acknowledge assignment of insurance payments for services rendered to Hearing Improvement Center, L.L.C.
I understand that I am financially responsible for all charges incurred for treatment including co-payments and deductibles for the above-named patient that are not covered by the insurance company(ies).

PATIENT SIGNATURE: _____**DATE:** _____
Or Parent/Legal Guardian or P-O-A

Parent/Legal Guardian or P-O-A (print name):_____

BILLING AUTHORIZATION STATEMENT

I hereby authorize The Hearing Improvement Center, L.L.C. to utilize outside billing representatives to call my insurance carrier for benefit information.
I authorize The Hearing Improvement Center, L.L.C. to utilize an outside billing representative to submit claims on my behalf.
I authorize the Hearing Improvement Center, L.L.C. to utilize an outside billing representative for any other responsibilities deemed necessary to expedite payments by my insurance carrier.

PATIENT SIGNATURE: _____**DATE:** _____
Or Parent/Legal Guardian or P-O-A

Parent/Legal Guardian or P-O-A (print name):_____