Quad Cities Audiology Consultants, P.C.
Patient Information Form

Date _____

Name _____ Date of Birth _____
(Legal name) Last First MI

Name you go by _____ (if different than legal name) SSN _____

Gender ☐ M ☐ F Pronouns _____
(*required: Must match health insurance gender for claims to be submitted) (*optional)

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email_____

If you consent to be contacted by text message, please enter your phone carrier (ex:AT&T,Verizon)_____

Employer _____ Occupation _____

Emergency Contact _____ Relationship _____ Phone _____

Family Physician _____ Referring Physician _____

Other referring or continuing care entity _____

Health Insurance Information

Primary Insurance Company _____ Policy Holder _____ DOB _____
Policy Holder Address (if different from patient) _____ Phone _____
Policy ID No. _____ Group No. _____ Policy Holder SSN _____
Insured Employer _____ Relationship to Patient _____
Secondary Insurance Company _____ Policy Holder _____ DOB _____
Policy Holder Address (if different from patient) _____ Phone _____
Policy ID No. _____ Group No. _____ Policy Holder SSN _____
Insured Employer _____ Relationship to Patient _____

If Patient is under 18 Years of Age (minor MUST be accompanied by parent or legal guardian)
Parent or Guardian Name _____Relationship to Patient_____
Birthdate _____ Social Security No. _____ Primary Phone _____
Address _____ City _____ State _____ Zip _____
Employer _____ Employer Phone _____

By providing us with your wireless/cell phone number, you are hereby granting us, and our agents or independent contractors, your consent to receive calls/texts on your wireless/cell phone number for correspondence and/or billing debt collections purposes.

We will gladly submit all services provided to your insurance company; however, it is your responsibility to see what coverage you have and if we are an in-network provider. In the event your insurance company does not pay you are responsible for all charges incurred.

I hereby authorize Quad Cities Audiology Consultants, P.C. to release my records to referring physician, family physician, insurance company and/or other listed above.

Responsible Party Signature _____ Date _____

Relationship/Self _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

□ **By checking this box and signing below, I acknowledge that I was offered a copy of Quad Cities Audiology Consultants, P.C. Notice of Privacy Practices.** The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website, www.audiologyconsultants.com and that any revised Notice of Privacy Practices will be made available. As part of the HIPAA Compliance Privacy Laws, we ask you to answer the following questions:

Please list the phone numbers we may leave messages/detailed medical information on.

Home _____ Cell _____ Work _____

Email Address _____

Do you have any particular person/family member(s) that you authorize to receive and discuss information regarding

your personal hearing information? _____ Yes _____ No

If yes, please provide:

Is this person your Power of Attorney for Medical purposes? _____ Yes _____ No

Name _____ Relationship _____

Phone Number _____

Additional persons/family members that you authorize to receive and discuss information:

Name _____ Relationship _____

Phone Number _____

Name _____ Relationship _____

Phone Number _____

I hereby authorize **Quad Cities Audiology Consultants, P.C.** to obtain or release any and all pertinent information

regarding my hearing health, as needed, to assist in my ongoing treatment to or from other health care providers.

This authorization remains in effect until revoked.

_____ _____

Printed name of patient or personal representative Date

_____ _____

Signature of patient or personal representative Date