Hearing HealthCare, Inc. **Today's Date:_____/_____/_____**

PATIENT INFORMATION:

(circle) Mr. / Mrs. / Ms. / Dr. Male / Female Adult / Child

Name: First_____Middle_____Last_____

Street Address: _____ **City**:_____

State:_____ **Zip Code**:_____ **Date of Birth**: _____/_____/_____

***Home Phone:** ( )_____ ***Work Phone:**( )_____

***Cell Phone**: ( )_____ ***Email Address**:_____

***Best phone contact number:** Home Work Cell

***May we call and leave a message and/or email you?** Yes No

REASON FOR TODAY'S VISIT: _____

_____

REFERRAL SOURCE: (provide referral source name if applicable or circle source)

Physician Name:_____Phone:_____

Friend or Family Member Name:_____

Newspaper Internet Newsletter Bulletin Letter Other_____

PERSON RESPONSIBLE FOR BILLING:

Responsible Person's Name:_____

Address (if different from patient): _____

Relationship to Patient: _____ Phone: ( )_____

Employer (if applicable) _____

Social Security Number:_____

Insurance Policy Holder's Name:_____

Insurance Policy Holder's Date of Birth:_____

EMERGENCY CONTACT:

Emergency Contact Name: _____

Relationship to Patient: _____ Emergency Contact Phone: _____

***If patient is a minor, please fill out phone/email information of responsible person.**

Hearing HealthCare, Inc. **Today's Date:_____/_____/_____**

NOTICE OF PRIVACY PRACTICES AND POLICIES

I give permission to Hearing HealthCare, Inc. to release my protected health information (PHI), verbal and written, contained in my medical record to my health insurance company, related healthcare providers, and Hearing HealthCare's business associates when required to complete my care. All other requests for information must be submitted in writing to Hearing HealthCare, Inc., by the patient or assignees.

In order for Hearing HealthCare, Inc. to mail me their newsletter, I authorize Hearing HealthCare, Inc. to disclose my name and address to our marketing partners, for the sole purpose of mailing . I understand that Hearing HealthCare, Inc. or it's marketing partner may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described.

All protected health information, i.e.; name and address, will never be sold .

If you do not want to receive our newsletter please check here: [ ]

I have been informed of and have available to me, Hearing HealthCare, Inc.'s complete Notice of Privacy Policy pursuant to HIPAA. The Notice provides information about how we may use and disclose the medical information that we maintain about you, and 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 and that any revised Notice of Privacy Practices will be made available. I understand that I am entitled to receive a copy of the Notice of Privacy Practices at any time.

I acknowledge and agree that regardless of my health insurance status, I am ultimately responsible for the balance of my account for professional services rendered and/or purchases made.

I have read all the information on this sheet and have completed the above answers, certify this information is true and correct to the best of my knowledge and hereby give Hearing HealthCare, Inc. permission to treat my concerns.

_____ Date: _____/_____ /_____

Patient Signature or Parent/Guardian if Patient is a Minor

_____

Print Name