Patient Information Form

Last Name _____ First Name _____ MI _____

Birth Date _____ Sex _____ Home Phone # _____ Other_____

Social Security #_____ Social Security # of Guardian (if minor)_____

Mailing Address (Street) _____

City _____ State_____ Zip Code _____

Email _____

Family Relation's Name _____ Phone # _____

Nearest Relative not living with you _____ Phone #_____

Whom may we contact in case of an emergency? _____ Phone #_____

How did you hear about our office? _____

Primary Ins. _____ Insurance ID# _____

Name of Policy Holder _____ Policy holders date of birth_____

Secondary Ins._____ _____ Insurance ID# _____

Who is financially responsible for this visit? _____ Phone # _____

I will pay today by Cash _____ Check _____ Credit Card _____ Other # _____

I authorize to release information requested with regard to processing my claims.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify of any changes in my health status or in the above information.

Signature _____ Date _____

Parent Signature if Minor _____ Date _____

Advanced
HEARING TECHNOLOGY

www.advancedhearcare.com Bonita Springs: (239) 948-3434 Naples: (239) 434-7000

Patient Authorization Disclosure

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 of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The patient may revoke or change this authorization at any time with a written request.

I wish to be contacted in the following manner (Check all that apply):

HOME TELEPHONE

___ Leave message with detailed information
___ Leave message with call-back number only

WORK TELEPHONE

___ Leave message with detailed information
___ Leave message with call-back number only
___ Do not call me at work

WRITTEN COMMUNICATION

___ Can we text you? If yes, your cell# _____
___ Can we mail to your home address: birthday letters, coupons, office newsletters, etc..
___ Can we email you? If yes, your email address:_____
___ Other: _____

Patient Signature: _____ **Date:** _____

___ Patient Refused to sign

In a further effort to protect your health information and the confidentiality of your healthcare, we ask that you designate below to whom the staff at Advanced Hearing Technology, Inc. may discuss your healthcare and scheduling needs as well as billing issues that may arise.

___ Only disclose information to myself

Name_____ Relationship _____ Phone_____

Name_____ Relationship _____ Phone_____

Patient Signature: _____ **Date:** _____

Personal History

a member of AUDIGYGROUP

Your Experience

We believe in, and strive to provide, a convenient location with ample parking and expect our staff to always be professional, courteous and helpful. To provide you with the highest level of service, please rate your experience of the following areas:

Location and accessibility	☐ Excellent	☐ Average	☐ Poor
Adequate parking	☐ Excellent	☐ Average	☐ Poor
Convenience of appointment times	☐ Excellent	☐ Average	☐ Poor
Friendly greeting	☐ Excellent	☐ Average	☐ Poor
Clean and welcoming environment	☐ Excellent	☐ Average	☐ Poor

What can we do to make your next visit more comfortable?

_____

_____

Insurance Information

Please give your insurance information to our front office staff so we can make a copy for our records.

*************PLEASE READ CAREFULLY AND SIGN BELOW*************

☐ I give permission to my AudigyCertified™ practice to release information, verbal and written, contained in my medical record and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.

☐ I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

☐ I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.

☐ 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 my AudigyCertified practice permission to treat my concerns.

I have read and understand all the above information.

_____ _____

A copy of this signature is as valid as the original — Date

Signature of Parent or Guardian if patient is a minor: _____