PATIENT INFORMATION

Name:		Nickname (if applicable):
Primary Phone Number:	☐ cell ☐ home ☐ work Cell carrier: ☐ Verizon ☐ Sprint ☐ AT&T ☐ Other:	
Alternate Phone Number:	☐ cell ☐ home ☐ work Cell carrier: ☐ Verizon ☐ Sprint ☐ AT&T ☐ Other:	
Date of Birth:	Gender: ☐ Male ☐ Female	Email address:
Emergency Contact Person: Relationship:		Phone Number:
Primary Care Physician:		How did you hear about us? ☐ Friend/Family ☐ Physician ☐ TV ☐ Internet

COMPLETE THIS SECTION IF PATIENT IS A MINOR				
Mother/Guardian Name:	Date of Birth:	Phone Number:	☐ cell ☐ home ☐ work	Cell carrier: ☐ Verizon ☐ Sprint ☐ Other: _____
Father/Guardian Name:	Date of Birth:	Phone Number:	☐ cell ☐ home ☐ work	Cell carrier: ☐ Verizon ☐ Sprint ☐ Other: _____

PATIENT/PARENT/GUARDIAN RESPONSBILITIES: By signing below, I acknowledge and understand that as the patient or parent/guardian, I am legally responsible for payment of all charges related to care received. Patient or parent/guardian is the responsible party that agrees to pay all services not covered by insurance as well as any reasonable attorney fees and cost of collection if account is placed in hands of an attorney or collection agency.

PATIENT/PARENT/GUARDIAN'S AUTHORIZATION TO REALEASE INFORMATION AND PAYMENT REQUEST TO INSURANCE: By signing below, I certify that the above information is correct. I authorize any holder of medical or other information about my child/myself to be released to Social Security Administration or its intermediaries or carrier and/or State in which you reside or its Fiscal Agents, or insurance company or its representatives any information needed for this or a related Medicare or other insurance claims. In consideration of services rendered, I transfer and assign to Advanced Audiology, LLC any payment which may become due for medical services under policies applicable to my dependent or me. Advanced Audiology, LLC does not accept Medicaid.

AUTHORIZATION TO SEND INFORMATION: By signing below, I authorize Advanced Audiology, LLC to contact me or my emergency contact either verbally, direct mail, email, or by telephone (including text message and voicemail) regarding my child's or my treatment, or to inform me of related events and services that may be of interest to me. I understand that this information will NOT be sold or shared with any other parties and can be revoked at any time.

AUTHORIZATION FOR TREATMENT/HIPAA ACKNOWLEDGMENT: By signing below, I authorize Advanced Audiology, LLC to perform testing, care and treatment/management services in person or through telehealth relating to my child's or my hearing health care needs. By signing below, I verify I am aware of the Health Insurance Portability and Accountability Act (HIPAA) of which Advanced Audiology adheres.

_____ _____

Patient/Parent/Guardian Signature: Date:

_____ _____

Witness Signature: Date: