HarmonyHearing & Audiology

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PATIENT INFORMATION

Name_____ Male ☐ Female ☐

Address_____

City_____ State_____ ZIP _____

Home Phone_____ Work Phone _____ Cell Phone_____

Date of Birth_____ Email_____

Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

Employer/School _____

Insurance Policy Holder (if not patient) _____ Relation to Patient_____

Date of Birth_____ Home Phone (if different)_____

Address (if different) _____ City _____ State_____ ZIP _____

How did you hear about us? _____

Primary Care Doctor_____ Phone or Location_____

Primary Insurance Company_____ Secondary Insurance _____

PLEASE SHOW ALL INSURANCE CARDS TO RECEPTIONIST

- I certify that the information provided above is correct.
- I hereby authorize insurance submissions and direct payment of any medical benefits for services provided to be sent directly to Harmony Hearing & Audiology, LLC. I further authorize the release of information to primary/secondary insurance companies.
- I consent to the usage of a copy of this authorization in place of the original.
- I understand that I am ultimately responsible for the balance on my account for services rendered, and it is my responsibility to know the rules and regulations of my health insurance, as well as what coverage is included with my specific plan.

☐ I acknowledge that, in compliance with the Health Insurance Portability Accountability Act (HIPAA), a Notice of Privacy Practices has been presented to me and I understand that a paper copy is available upon request. (Please check or initial the box)

Signature _____ Date_____