

Patient Information

Patient Legal Name _____ DOB: _____

Preferred name _____ Occupation _____

Insurance Policy holder name/relationship (if different than patient) _____

Home # _____ Mobile # _____ Best # for message: Home Mobile

Mailing Address _____

Secondary Address _____

Emergency Contact _____ Phone# _____ Relationship to Patient _____

Primary Care Physician _____ Clinic Name _____

How did you find out about us? _____

(Insurance, Friend/Family member, Primary Care Provider, Online, Newspaper)

Patient Authorized methods of communication:

Email Consent:

Not all methods of communication offer the same level of privacy. I understand the risks and give permission for email.

Email address: _____

Text/SMS Consent:

Types of messages: Conversational, customer care, appointment and billing reminders, Reply STOP to opt-out; Reply HELP for support; Message & data rates may apply; Messaging frequency may vary.

 I consent to receive Text/SMS I do not consent to receive Text/SMSTo see our Privacy Policy and Terms of Service, visit: <https://www.foxvalleyhearingcenter.com/privacy-policy/>

Individuals Permitted Access to my Information:

I give permission to release information to my family member or friend listed below.

Name & Relationship _____ Phone # _____

Name & Relationship _____ Phone # _____

HIPAA and Financial Information

I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices. It is available to review on the company website as well. I understand that if services rendered today are not covered by my insurance policy, I am responsible for payment. I also understand that it is my responsibility, not the responsibility of the provider, to know the benefits provided by and limitations of my health insurance policy. I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge, and I hereby give my hearing care provider permission to treat my concerns. I authorize the release of any medical or other information necessary to process claims or to related healthcare providers as necessary. I also request payment of government and insurance benefits to myself or to the party (supplier) who accepts assignments of service.

I have read and understand all the above information.

Patient Signature/Parent or Guardian _____ Date _____