PATIENT INFORMATION Chart # _______________ Date: _________________

Patient Name ____ (circle) M F

SSN ____ DOB _____ / _____ / ________

Primary Insurance________________________ID #_________________________

Insured Name:_____________________Relationship______________Insured DOB:_____________________

Secondary Insurance________________________________ ID# ____________________________

Insured Name:_____________________Relationship______________Insured DOB:_____________________

Home Phone # _________________________________ Cell Phone # _________________________________

Mailing Address ________________________________ City _______________ST______Zip Code _________

May we contact you via email? Y N Email Address:____

Marital Status ____ Married ____ Single ____ Widowed ____ Divorced

Employer/ Occupation ____

Spouse Name ____ DOB _____ / _____ / _________

Emergency Contact ____________________________________ Phone # ______________________________

Relation to patient __________________________

If the patient is under the age of 18, this section must be completed

Mother ______________________________ Father __________________________________

Mother's SSN __________________________ Father's SSN ______________________________

Mother's Birth date _____________________ Father's Birth date __________________________

Mother's Employer ______________________ Father's Employer ___________________________

Mother's Work Ph # ______________________ Father's Work Ph # __________________________

Primary Care Physician ____ Phone # __________________________

Address ____

If your charges are billable to insurance a claim with your personal information will be filed. If you have been referred by another health care provider, a copy of your test results will be sent to that provider. However, in order for us to discuss with anyone else (a caregiver, a spouse, a child, a neighbor) your health information or your account, we need your written permission. Please list the name (s) and relationship of anyone that can talk to us about your information. This permission will remain in effect until you rescind permission in writing.

____

Signature: ____ Date:___________________________________

How did you hear about us?

____ Mail ____ Newspaper Ad ____ Radio ____ Insurance

____ Yellow Pages ____ Health/Senior Fair ____ Website ____ TV Ad______________

____ Referred by a Friend ____

____ Referred by a Physician ____

____ Other ____

Reason for Appointment ____

(Continued on other side)

FINANCIAL INFORMATION

PLEASE PRESENT YOUR INSURANCE CARDS AND PHOTO IDENTIFICATION TO OUR OFFICE STAFF AT CHECK IN

********** Please read carefully and sign below **********

I give permission to Tennessee Audiology Partners, d/b/a COOKEVILLE AUDIOLOGY AND HEARING AIDS; d/b/a McMINNVILLE HEARING CENTER to release information, verbal and written, contained in my medical record and other related information, to my insurance company, and related healthcare providers. This authorization will remain in effect indefinitely or until a new authorization is executed by me.

I authorize my insurance benefits to be paid to Tennessee Audiology Partners, d/b/a COOKEVILLE AUDIOLOGY AND HEARING AIDS; d/b/a McMINNVILLE HEARING CENTER. I understand that I am responsible for my account balance being paid in full even if an insurance claim is filed. 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 understand that many insurance companies require that a referral be faxed to COOKEVILLE AUDIOLOGY AND HEARING AIDS and McMINNVILLE HEARING CENTER prior to my appointment. I will make every effort to ensure that this is handled in a timely manner by my primary care physician.

I understand that payment may be made by check, cash, Visa, or Mastercard. I understand that should my account become delinquent that my billing information will be forwarded to a collection agency.

I understand that payment for any co-pays or deductibles will be collected prior to my visit. I also understand that in the event that a hearing aid is recommended to me by COOKEVILLE AUDIOLOGY AND HEARING AIDS or McMINNVILLE HEARING CENTER, the specific costs related to the hearing aid will be discussed with me at that time and a contract will be executed.

I authorize COOKEVILLE AUDIOLOGY AND HEARING AIDS or McMINNVILLE HEARING CENTER to perform evaluations for procedures as the audiologist deems necessary for treatment and/or evaluation. Authorize _____(initials) DO NOT AUTHORIZE _______ (initials) _______________ (Date) I also understand that my audiologist may provide information via marketing packets regarding new technologies or hearing solutions as it becomes available if my audiologist believes that it will benefit me. Authorize ________(initials) DO NOT AUTHORIZE _______________ (initials) _________________(Date)

I have received a copy of COOKEVILLE AUDIOLOGY AND HEARING AIDS or McMINNVILLE HEARING CENTER privacy policy regarding my health information but also understand that that a copy is available to me upon my verbal or written request. I also understand that a copy of this privacy notice hangs in the waiting area of COOKEVILLE AUDIOLOGY AND HEARING AIDS or McMINNVILLE HEARING CENTER and I will be offered a copy as any changes are made to the notice. _______(Initials) ___________________

Date

I understand that the preferred method of contact for COOKEVILLE AUDIOLOGY AND HEARING AIDS or McMINNVILLE HEARING CENTER regarding appointments, test results, and account questions will be my **home phone number** as indicated on the front of this form. Any specific instructions for calling are as follows: ____

____

I have read and completed all the information on this form in its entirety. I certify that the information is true and correct to the best of my knowledge and hereby give COOKEVILLE AUDIOLOGY AND HEARING AIDS and McMINNVILLE HEARING CENTER permission to treat my concerns. **I have read and understand all of the above information.**

____ _____________________

(Signature – a copy of this signature is as valid as the original) Date

Signature of Parent or Guardian ____ ____________

Date