Welcome

Patient Intake & HIPAA

Please be sure to complete both sides

Patient Personal Information

Patient Name: _____ Date of Birth: _____/_____/_____

Preferred Name: _____ Sex: F M Spouse's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone : _____ Cell Phone: _____ Email: _____

Preferred method of contact for appointment reminders: ❑ Text ❑ Email

Whom may we speak with regarding your care? _____

Are you: full/time ____ part/time ____ not employed ____ self employed ____ retired ____ active military ____

Employer (if applicable): _____

Did anyone accompany you to today's appointment? (name and relationship) _____

How did you hear about us/ who can we thank for the referral? _____

Primary Physician: _____ City: _____

If your physician has referred you to our practice, a report will be sent to them.

Insurance Information

Insurance cards will be copied for carrier name & ID#, however we do need the following information:

Subscriber Name: _____ DOB: _____

Patient relationship to insured: Self ___ Spouse ___ Child ___ Other ___

Secondary Ins Subscriber Name: _____ DOB: _____

Patient relationship to insured: Self ___ Spouse ___ Child ___ Other ___

Assignment And Release

I, the undersigned certify that I (or my dependent) have insurance coverage with the insurance company above and assign directly to Accent on Hearing, Inc., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance company. Delinquent accounts can be charged an interest rate of 1.5% of the unpaid balance and all costs incurred by Accent on Hearing, Inc., in collecting such payment, including attorney's fees and court costs. I hereby authorize Accent on Hearing, Inc., to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I acknowledge that a copy of Accent on Hearing's Notice of Privacy Practices has been made available to me. I further acknowledge that a copy of the current notice is available in the reception area and electronically on the website, www,accentonhearing.net. I may request a copy of any amended Notice of Privacy Practices at each appointment.

- This Notice informs me how Accent on Hearing will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Accent on Hearing may use and share my health information for other than treatment, payment, and healthcare operations.
- Accent on Hearing will also use and share my health information as required/ permitted by law.

_____
Printed name of patient or personal representative

_____
Signature of patient or personal representative

_____
Date