PATIENT INTAKE FORM

THANK YOU for scheduling your appointment with us!

Name: ____ **Nickname:** ________________________________

Address: _______________________________ **City, State, and Zip Code:** ____________________________

Phone Numbers Cell: __________________ **Home:** __________________ **Work:** _____________________

DoB: ___________________ **Email Address:** ____

If you live in a senior citizen facility, please tell us which one: ____

How do you prefer to be notified of appointments? Text: _____ Email: ______ Cell: _____ Home Ph: _____

Sex: M F Marital Status: Married Single Other Widow Divorced

Employment: Full Time Part Time Retired Student: Full Time Part Time None

Primary Care Physician: _____________________________ City/State: _______________________________

Did a physician refer you to us? __________ If so, who was it? _____________________________________

May we share the results of your appointments with your primary care physician: Yes _____ No ______

Please rate your hearing on a scale of 1-10 **without the use of aids**. 1 being cannot hear at all and 10 being you can hear great. __________.

If applicable, please rate your hearing on a scale of 1-10 **with the use of aids.** 1 being cannot hear at all and 10 being you can hear great. __________.

All of your information with us is kept private and confidential. If there is a loved one or family member that you would allow us to release your information to, please specify their name, relation, and phone number below. Otherwise, information about you and your care **will not** be released.

Full Name:	Relation and Phone Number:
_________________________________	____
_________________________________	____

How did you learn about us? ____

If referred to us by a patient or friend, may we have your permission to use your name in a thank you note to that person who referred you? Yes No

24 Hour Appointment Cancellation Policy

If you miss your appointment, cancel or change your appointment with less than 24 hours' notice, you will be charged: $30 for appointments 30 minutes and under
$45 for all other appointments

This policy is in place out of respect for our audiologist and patients. Cancellations with less than 24 hours' notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot and get the care that they may need.

By signing below, you acknowledge that you have read and understand the Cancellation Policy of Now Hear This® as described above.

We thank you for your understanding and cooperation.

Date: ________________________ ________________________________
Patient Signature

Agreement & Authorization

I understand that if services provided by Now Hear This® are not authorized or paid for by my insurance company, I will be responsible for all charges incurred. I hereby agree to pay in full any and all charges for services rendered that are not covered by my health insurance company.

Now Hear This® is authorized to release to my insurance company any and all medical information necessary to process my claim for reimbursement of charges incurred for services rendered or for the purpose of determining continued eligibility. Now Hear This® is also authorized to release medical information to my referring physician or health care provider to monitor progress.

Now Hear This® is also authorized to release information about my care and appointments to providers and/or specialist that they may need to refer me to for additional care.

I hereby authorize and direct my insurance company or companies to make direct payment to Now Hear This® under any and all applicable coverage, including major medical, for covered charges for services rendered.

I further understand that Now Hear This® follows all HIPAA guidelines. The HIPAA guidelines are available for my review any time that I request them. By reading and signing this document, I agree that I have been given an opportunity to review the HIPAA guidelines.

Date: ________________________ ________________________________
Patient Signature

Thank you!

Please give us your health insurance card(s) and driver's license to be scanned into your file.