

PATIENT INTAKE FORM

THANK YOU for scheduling your appointment with us!

Name: _____ Nickname: _____

Address: _____ City, State, Zip Code: _____

For apartments, please include apartment number.

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 O Marital Status: Married Single Widow Divorced Domestic Relationship Other

Employment: Full Time Part Time Retired Student Other

Language: Is English your first language? Yes No If not, are you fairly fluent in English? Yes No

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 _____

Are you currently receiving hospice care? 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. _____.

Your information with us is kept private and confidential. If there is a loved one, family member, or caregiver that you approve to have your information released to, please specify their information below. Otherwise, information about you and your care **will not** be released.

<u>Full Name</u> :	<u>Relation and Phone Number</u> :
_____	_____
_____	_____

Check if
POA

How did you learn about us? _____

If referred by a patient or friend, can we use your name in a thank you note to them? 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: \$45 for appointments 30 minutes and under
\$75 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 possibly getting 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.

I give permission to Now Hear This® to contact me by phone, email, mail, and/or text for appointment reminders, hearing aid care/repair information, as well as marketing and promotions on new hearing aid technology.

Date: _____

Patient Signature

Please provide your health insurance card(s) and driver's license for your file.