First Name_____ MI_____ Last _____ Date of Birth_____

Address:_____ City_____ State_____ Zip Code_____

Primary Phone_____ Secondary Phone _____ Sex: M F

Email:_____ Social Security Number: _____

Marital Status: Married Divorced Single Widowed

Employer: _____ Primary Care Physician_____

Emergency Contact_____ Relationship: _____ Phone_____

Responsible Party (if other than Self)

First Name: _____MI _____Last _____ Relationship to patient _____

Address (if different than above)_____

Primary Phone _____Date of Birth_____

Primary Insurance Coverage _____

Secondary Insurance Coverage _____

Insurance Authorization and Assignment: I hereby authorize Premier Hearing and Balance, LLC. to provide all necessary information to insurance carriers. I assign to Premier Hearing and Balance, LLC all payments for audiological services rendered for me or my dependents. I understand that my insurance coverage is an agreement between myself and my carrier and that I am responsible for any amount not covered by my carrier. I understand that it is my responsibility to obtain benefit and coverage information prior to services being rendered. By providing my email address and choosing yes, I am agreeing to receive educational and promotional messages from Premier Hearing and Balance, LLC. I understand that I can opt-out at any time.

Signature_____ **Relationship if not patient**_____

Date_____

PATIENT PRIVACY CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare options. I also understand that you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name _____ Relationship to patient (if not self) _____

Signature _____ Date_____

Please list who we can speak to about your care:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Date:				
Medications List				
Patient Name:			**DOB:**	
MEDICATION ALLERGIES: List all medications you are allergic to.				
Medication name	**Type of reaction, such as a rash or breathing difficulties**			
PRESCRIPTION MEDICATION				
Medication name	**Prescribing doctor's name**	**Reason for taking the medication**	**Dosage**	**How often?**
NONPRESCRIPTION MEDICATIONS, VITAMINS, and SUPPLEMENTS				
Medication name	**Reason for taking the medicine**	**Dosage**	**How often?**	