PROFESSIONAL HEARING SERVICES INC.

Patient Information-This form **MUST** be completed prior to appointment

Name:_____ Date of Birth:_____

Gender: _____ SSN:_____

Address:_____City:_____

State:_____ Zip Code:_____ Primary Doctor:_____

Phone Number: _____Email: _____

Emergency Contact Name: _____

Relationship to Patient: _____ Phone Number: _____

IF THE PATIENT is under the care of a guardian or under 18, responsible party must complete remainder of this section

Name of Responsible Party: _____

DOB: _____ SSN: _____ Email: _____

Phone Number: _____

Employer: _____ Employer Phone: _____

- I give permission for Professional Hearing Services Inc to release information, verbal and written, contained in my medical record and other relation information, to my insurance company, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons.

  _____Initial to **refuse** permission to release records

- I acknowledge that I have received and reviewed the Health Insurance Portability and Accountability Act (HIPAA) policy of this office
- 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 I may be charged up to $50 for failure to attend or cancel less than 24 hours prior to a scheduled appointment
- I have read all the information above, completed the answers and certify this information is true and correct to the best of my knowledge and hereby give Professional Hearing Services Inc permission to treat my concerns.

Signature: _____Date: _____

Signature of Parent of
Guardian:_____Date:_____