Mt. Harrison Audiology
and Hearing Aids LLC

Patient Information Form

Patient Name:	First Middle Last
Date of Birth:	

If patient is under the age of 18, the responsible party must fill out the following:

Name of Responsible Party:	First Middle Last			
Home Phone #		Cell Phone #		
Work Phone #		Patient's SSN		
Preferred contact method	OHome Phone	OWork Phone	OCell Phone	OEmail O Post Mail
Email Address:				
Mailing Address:	Street City State Zip			
Secondary Address:	Street City State Zip			
Age:		Occupation:		
Marital Status:	OMarried	OSingle	OWidowed	ODivorced
Spouse Name:				
Emergency Contact:		Phone #		
Relationship to Patient:				
Primary Care Physician:		Phone #		

Insurance Information:

Primary Insurance:		Policy/ID #		Group #	
Subscriber's Name:		Patient Relationship to Subscriber:			
Subscriber's DOB:		Subscriber's Employer:			
Secondary Insurance:		Policy/ID#		Group#	

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Please read carefully and sign below:

- I give permission to Mt. Harrison Audiology and Hearing Aids LLC to release information, written and verbal (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.
- I authorize Mt. Harrison Audiology and Hearing Aids LLC to use and release my protected health information for marketing related to hearing care products and services. Such marketing in this practice includes the sending of thank you notes and birthday cards, as well as reminders for annual examinations. [*We do not sell your personal health information. IF we send a marketing piece, it is to a list purchased for such activities, not from our database. We do send email newsletters to our patient database, which you are welcome to opt out of at any time.*] I understand that this marketing authorization is in effect until a revocation is received by the practice. If you do not wish to be part of these activities, please indicate here:_____
- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
- I authorize Mt. Harrison Audiology and Hearing Aids LLC to apply for benefits on my behalf for services rendered by Mt. Harrison Audiology and Hearing Aids LLC. I certify that the information I have reported with regard to my insurance is correct and further authorize the release of any necessary information, including medical records for this or any related claims. I also authorize Mt. Harrison Audiology and Hearing Aids LLC to collect any payment made by an insurance carrier for services rendered and billed by Mt. Harrison Audiology and Hearing Aids LLC.
- 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 have read all the information on this sheet, completed the above answers, and certify that this information is true and correct to the best of my knowledge, and I hereby give Mt. Harrison Audiology and Hearing Aids LLC permission to treat my concerns.

I have read and understand all the information above.

Patient Signature (A copy of this signature is as valid as the original) Date

Signature of Parent of Guardian Date