acadianhearing

## ADULT PATIENT INFORMATION

Name:_____ ☐ MALE ☐ FEMALE
First M. Last

Address:_____ Apt/Suite:_____

City:_____ State:_____ Zip Code:_____

Social Security # _____-_____-_____ DOB:_____/_____/_____ Age:_____

Home Ph. ( )_____-_____ Work Ph. ( )_____-_____ Cell Ph. ( )_____-_____

*We may leave messages concerning scheduling. Please let us know if you do not want this information disclosed in a message.*

Primary Care Physician _____ Referring Physician _____

Occupation:_____ Email address _____

Marital Status_____ Spouse or Guardian: _____

How did you hear about Acadian Hearing Services? (Please check one below)

☐ Yellow pages ☐TV ☐Physician: Dr._____ ☐Friend_____ ☐Other_____

**List anyone you would like to grant access to your medical information? (i.e. Spouse, Child, Caretaker, etc.)**

Name: _____ Relationship:_____Phone:_____

Name: _____ Relationship:_____Phone:_____

Name: _____ Relationship:_____Phone:_____

## INSURANCE INFORMATION

Please disclose **all** insurance coverage/policies and give all cards to the front desk. Failure to do so may result in charges becoming patient responsibility.

**Primary Insurance**:_____ Policy Holder: _____

**Secondary Insurance**:_____ Policy Holder: _____

**INFORMED CONSENT AGREEMENT:**

I understand that evaluation of the hearing/speech systems requires the use of specialized instrumentation. During the course of this evaluation, I understand that various earphones with be placed over or in my ears and various probes may be placed in the external ear canal. In the event amplification or other custom devices are required, I consent to placement of foam or cotton blocks in the external ear as well as, materials to make ear impressions.

I do hereby authorize Acadian Hearing Services to submit claims to my insurance company/companies on my behalf, and my insurance company/companies to make payments directly to Acadian Hearing Services for professional services rendered.
**I UNDERSTAND I AM RESPONSIBLE FOR ANY DEDUCTIBLE, CO-PAYMENT, AND OTHER AMOUNTS NOT COVERED BY MY INSURANCE COMPANY/COMPANIES.** I/We agree to be bound by the above terms and conditions.

AS REQUIRED BY HIPAA ACT 1996, I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES FOR THIS PRACTICE AND A COPY HAS BEEN MADE AVAILABLE TO ME.

Signed: _____ Date: _____