PATIENT INFORMATION

NAME:____ **DATE:**_____________________

MAILING ADDRESS:____

____

HOME PHONE:_________________________________ **CELL PHONE:**_________________________

DATE OF BIRTH:______________________ **SPOUSE'S NAME:**___________________________

E-MAIL ADDRESS:____

PRIMARY CARE DOCTOR:____

HISTORY OF MAJOR ILLNESS OR ALLERGY:____

____

Specifically: _____Diabetes _____Heart Disease _____ Stroke_____ History of Bleeding _____ Other_______________

A **medical physician** must provide a written referral for your appointment today. If the referral is not received by Audiology Specialists, LLC by the time of the appointment, you may be responsible for the full expense of the services provided.

If Audiology Specialists, LLC has not received your referral from your physician upon the time of your appointment, you will have five business days to provide one to this Office. The referral **MUST REFLECT THE DATE OF YOUR APPOINTMENT OR BEFORE.**

If a written referral is not provided within this grace period, you will be responsible for all charges for procedures provided from this Office.

I also agree to pay any charges if my Insurance Carrier denies coverage.

I understand this Policy and agree to pay any charges that I have incurred.

I request that payment of authorized Insurance Carrier benefits be made on my behalf to Audiology Specialists, LLC for any services furnished to me. I authorize the holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its Agents any information needed to determine these benefits or the benefits payable for related services. By signing below, you authorize the release of any information required by your Insurance Carrier for payment of benefits.

____ _________________________________

Patient/Guardian Signature **Print Name**