Advanced Hearing and Balance Center, LLC
Patient Profile and Consent

Legal Name (First MI Last)		Date of Birth	Patient SS#
Address		Sex:	Marital Status
City, State, Zip		Phone #1 (Type of Number)	Phone #2 (Type of Number)
Email	Primary Physician		Please tell us how your heard about our practice
Policy Holder Name (if different from above):	(if different from above) Policy Holder SS#		(if different from above) Policy Holder Date of Birth:
Employer	Occupation		

Insurance Information

☐ Card(s) Attached	Primary Insurance	Secondary Insurance
Insurance Name/Subscriber Name		
Subscriber Relationship to Patient		
Subscriber Employer/Ins Policy# and Group#		
Office Visit Copay		

Consent for Treatment: I, the undersigned, voluntarily agree to the tests, procedures, and/or treatments which the audiologist has deemed necessary and which are administered to or performed on me under the direction of the audiologist.

Consent for Treatment of Minors: I, the undersigned, understand that a minor child (17 and under) must have my consent to be treated. I understand that I must be present at each appointment for any child aged 14 and under. If the child is between the ages of 15 and 17, I understand that I must send a note with the child to the appointment consenting for the child to be treated. The notes must contain the date, a statement of consent, and my signature. Further, I understand that consent for treatment does not alter the legal requirements for confidentiality.

Consent to Communicate Medical Results: I, the undersigned, understand that medical results will be communicated directly to me unless I specifically identify individuals to whom information may be communicated (see box below to authorized other family members to receive results). Please indicate how we may inform you of test results (check all that apply):

	Use info above	Okay to leave voice mail?	Ok to leave message with another person (see below)
❒ Call my work number	❒	❒ Yes ❒ No	❒ Yes ❒ No
❒ Call my cell phone:	❒	❒ Yes ❒ No	❒ Yes ❒ No
❒ Call my home number	❒	❒ Yes ❒ No	❒ Yes ❒ No
❒ Mail to my home address	❒	❒ Mail to a different address (at right):	
❒ Mail to my Email	❒	❒ Yes ❒ No	

In the event that I am not available to receive medical results when called upon, I authorize a representative of Advanced Hearing and Balance Center to leave medical information with any of the names identified below. It is my responsibility to notify these persons that such information may be left with them and I agree not to hold Advanced Hearing and Balance Center responsible for information not conveyed to me through these persons.

Family/Caregiver Information

Name (First MI Last)	Address	
Phone	Relation	OK to Release Results? Yes ❒ No ❒

Emergency Contact Information: SAME AS ABOVE: ❒

Name of relative or friend to contact in case of an emergency		
Name	Relation	Phone

Acknowledgements: (please check both boxes)

❒ I certify to the accuracy of the above information and understand that I am personally responsible for the full amount of my charges regardless of insurance coverage. I authorize the release of any medical or other information necessary to process claims.

❒ I also hereby acknowledge that I received the Notice of Privacy Practices for Advanced Hearing and Balance Center.

_____ _____

Signature **Date**