

# PA Center for Hearing & Balance, LLC

*Better Hearing. Better Living.*

**Welcome. Please tell us a little about yourself by completing these forms.**

How did you hear about us? \_\_\_\_\_

## PERSONAL INFORMATION:

PATIENT'S NAME \_\_\_\_\_  
FIRST MIDDLE LAST

MAILING ADDRESS \_\_\_\_\_  
CITY STATE ZIP

TELEPHONE (HOME) \_\_\_\_\_ (CELL) \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ PRIMARY LANGUAGE \_\_\_\_\_

FULL NAME AND PHONE NUMBER OF PRIMARY CARE PHYSICIAN \_\_\_\_\_

NAME & TELEPHONE OF NEAREST RELATIVE \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_ May we contact you via email? YES \_\_\_\_\_ NO \_\_\_\_\_

## INSURANCE INFORMATION - PLEASE READ AND SIGN/INITIAL:

**DISCLAIMER:** As a professional courtesy, we will submit your claim to your insurance provider, but this does not guarantee their payment. You accept responsibility for co-pay, deductibles, or uncovered procedures. If you have a hearing aid benefit, you may be required to pay for your hearing aid upfront. Upon receipt of payment from your insurance company, we will reimburse you for the amount that the insurance company covered/paid. **PLEASE INITIAL:** \_\_\_\_\_

Name of insured \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Insured's Date of Birth \_\_\_\_\_

Insured's Employer \_\_\_\_\_

I hereby authorize Liliana Piccinini, Au.D. and/or PA Center for Hearing & Balance and/or her associates to furnish information to my insurance carrier concerning my illness and treatment, and I hereby assign to her all payments for services rendered to my dependents or myself. I understand that I am responsible for payment.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## PLEASE READ AND SIGN/INITIAL:

In order to keep your medical file up to date, we will be happy to provide your physician with a copy of our audiological findings. **Please initial ONE** →  
Send a copy to my physician \_\_\_\_\_ (initial)  
**DO NOT** send a copy to my physician \_\_\_\_\_ (initial)

**Privacy Practice Notice:** According to government law, we are required to make available to you a copy of our privacy practice notice. Your signature below acknowledges your receipt of such:

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

