## *FAMILY HEARING CARE*

Patient Name _____ Male or Female
(First) (Middle Initial) (Last)

Address: _____ City _____ State ____ Zip _____

Home # ( )_____ Cell # ( )_____ E-Mail:_____

Date of Birth: _____ Age: _____ Soc Sec #:_____

Employer Name: _____ Employer Phone: _____

Address: _____
(City) (State) (Zip)

Family Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

## *SPOUSE/RELATIVE OR CAREGIVER INFORMATION:*

Name: _____ Male or Female
(First) (Middle Initial) (Last)

Relationship to patient: _____ Spouse's DOB: _____

Address: _____ City: _____ State: _____ Zip: _____
(If different from above)

Home #:_____ Work #:_____ Cell #:_____

E-Mail: _____

## *EMERGENCY CONTACT PERSON:*

Name: _____
(First) (Middle Initial) (Last)

Relationship to Patient: _____

Home #:_____ Work #: _____ Cell #: _____

********* NOTE: IF YOU HAVE PROVIDED YOUR INSURANCE CARDS TO THE FRONT DESK, YOU WILL STILL NEED TO COMPLETE THE FIRST (2) TWO LINES OF THE INSURANCE PORTION***

## *PRIMARY INSURANCE*

**Name of Insured:_____ Date of Birth:_____**

**Employer Name:_____**

Insurance ID#:_____ Group#:_____

Insurance Plan Name:_____

Address:_____
(City) (State) (Zip)

*SECONDARY INSURANCE*

**Name of Insured: _____ Date of Birth: _____**

**Employer Name: _____**

Insurance ID#: _____ Group #: _____

Insurance Plan Name: _____

Address: _____
(City) (State) (Zip)

## Release and Authorization

** I authorize the audiologist, Kelsie Tomlin, of Family Hearing Care and her staff to give me reasonable and proper medical care. I authorize the audiologist to give medical information to my appropriate family members and to send letters to other healthcare providers as appropriate.

** I authorize Family Hearing Care to release any medical information to my insurance company or HCFA to file a claim for medical. I also request that payment under the medical insurance program be made directly to the above named medical group on any bills of services furnished to me. I understand that I am financially responsible for any balance not covered by my insurance carrier, including Medicare. (A copy of this signature is as valid as the original.)

** I am responsible for all financial obligations of health services for the above patient; for reimbursement and payment of claims from my insurance company. I understand that I am responsible for any amount not covered by insurance.

** In consideration of the services to be provided to the patient, I/we hereby guarantee payment in full of the patients account in accordance with the financial arrangements made at the time of service or, if no such arrangements are made, in the event of default in payment, reasonable collection agency fees equal to thirty (30%) percent of the delinquent balance and reasonable attorney fees, shall be added to the amount due on the account, plus any applicable court costs.

** You expressly consent and agree that Family Hearing Care may use written, electronic or verbal means to contact you. This consent includes, but is not limited to, contact by manual methods, prerecorded or artificial voice messages, text messages, emails. You agree that Family Hearing Care may use your email address or any telephone number you provide, now or in the future, including a number for a cellular phone or other wireless device, regardless of whether you incur charges as a result.

**Signature of Patient or Legal Guardian** **Date**