Patient Information Form

HRC HEARING REHAB CENTER

Verified _____ Date _____ Verified _____ Date _____

Date _____ Verified _____ Date _____ Verified _____ Date _____

Patient Name _____ **DOB** ____/____/____
First MI Last mm dd yyyy

Home Phone # _____ **Cell Phone #** _____

Work Phone # _____ **May we leave a message? (Check all that apply):** ○ Home ○ Cell ○ Work

Email Address _____

Mailing Address _____
Street City State ZIP

Age _____ **Sex** M F **Occupation/Prior Occupation (if retired)** _____

With whom do we have permission to discuss your results and treatment? Please list (e.g., spouse, children, parents): _____

Marital Status ○ Married ○ Single ○ Widowed ○ Divorced ○ Long-term commitment

Spouse Name _____

Emergency Contact _____ **Phone #** _____

Relation to Patient _____

Primary Care Physician _____ **Phone #** _____

May we send a report to your primary care physician? ○ Yes ○ No

How did you hear about us?

○ Mail ○ Newspaper ad ○ Promotional call ○ Radio ○ Insurance

○ Yellow pages ○ Sponsored event ○ Health/Senior Fair ○ Website ○ Employer

○ Referred by friend _____ ○ Referred by physician _____

○ Other _____

Reason for Appointment _____

_____

Turn over...

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We strive to provide a convenient location with ample parking, and we expect our staff to always be professional, courteous, and helpful. To provide you with the highest level of service, please rate your experience in the following areas:

Location and accessibility	○ Excellent	○ Average	○ Poor
Adequate parking	○ Excellent	○ Average	○ Poor
Convenience of appointment times	○ Excellent	○ Average	○ Poor
Friendly greeting	○ Excellent	○ Average	○ Poor
Clean and welcoming environment	○ Excellent	○ Average	○ Poor

What can we do to make your next visit more comfortable?

Insurance Information

Please give your insurance information to our front office staff so we can make a copy for our records.

Please read carefully and sign below.

- I hereby give my permission to Hearing Rehab Center to use and disclose verbal and written protected health information (PHI) about me to carry out treatment, payment, and health care operations. The Notice of Privacy Practices provided by Hearing Rehab Center describes such uses and disclosures more completely and can be requested at any time.
- With this consent, Hearing Rehab Center may call, email, or mail to my home (or other alternative location) any items that assist the practice in carrying out health care operations, such as appointment reminder cards and clinical communication. I understand that this communication authorization is in effect until a revocation is received by Hearing Rehab Center.
- I acknowledge that I have the right to review the Notice of Privacy Practices at length under the Health Insurance Portability & Accountability Act (HIPAA) prior to signing this consent.
- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.
- I have read all of the information on this sheet, completed the above answers, and certify that this information is true and correct to the best of my knowledge, and I hereby give Hearing Rehab Center permission to treat my concerns.

I have read and understand all the above information.

Patient Signature (A copy of this signature is as valid as the original) Date

Signature of Parent or Guardian Date