ADULT INFORMATION FORM

Patient Name: _____
First Middle Last

Date of Birth: _____

Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____ Patient's SSN: _____

Preferred contact method: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email ☐ Post Mail

Email Address: _____

Mailing Address: _____
Street City State Zip

Secondary Address: _____
Street City State Zip

Age: _____ Occupation: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Spouse Name: _____

Emergency Contact: _____ Phone #: _____

Relationship to Patient: _____

Primary Care Physician: _____ Phone #: _____

Insurance Information:

Primary Insurance: _____

Policy/ID # _____ Group #: _____

Subscriber's Name: _____

Patient Relationship to Subscriber: _____

Subscriber's DOB: _____ Subscriber's Employer: _____

Secondary Insurance: _____

Policy/ID#: _____ Group#: _____

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

Please read carefully and sign the document:

- I give permission to Mt. Harrison Audiology and Hearing Aids, LLC to release information, written and verbal (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, employer, related health care providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.
- I authorize Mt. Harrison Audiology and Hearing Aids, LLC to use and release my protected health information for marketing related to hearing care products and services. Such marketing in this practice includes the sending of thank you notes and birthday cards, as well as reminders for annual examinations. [We do not sell your personal health information. IF we send a marketing piece, it is to a list purchased for such activities, not from our database. We do send email newsletters to our patient database, which you are welcome to opt out of at any time.]
  I understand that this marketing authorization is in effect until a revocation is received by the practice. If you do not wish to be part of these activities, please indicate here:
- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
- I authorize Mt. Harrison Audiology and Hearing Aids, LLC to apply for benefits on my behalf for services rendered by Mt. Harrison Audiology and Hearing Aids, LLC.
- I certify that the information I have reported with regard to my insurance is correct and further authorize the release of any necessary information, including medical records for this or any related claims. I also authorize Mt. Harrison Audiology and Hearing Aids, LLC to collect any payment made by an insurance carrier for services rendered and billed by Mt. Harrison Audiology and Hearing Aids, LLC.
- 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 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 Mt. Harrison Audiology and Hearing Aids, LLC permission to treat my concerns.

I have read and understand all the information above.