# PATIENT INFORMATION SHEET

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Today' s Date

Patient Name_____

Address_____City_____State_____Zip_____

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Birthdate _____ Age_____ M or F Social Security # (last 4 digits only)_____

Home Phone #_____ Work Phone #_____

Cell Phone# _____may we text you reminders & updates? Yes or No

Email Address _____may we email you reminders & updates? Yes or No

Occupation (or former occupation)

_____

Marital Status _____ Spouses Name_____

Primary Physician _____ Referred By_____

May we share your audiology information with your primary and/or referring physician?

_____

Your information is used and protected with the strictest of confidence. Your information will only be transmitted to other parties; example, insurance companies, lawyers or other medical providers with your written consent. We use your information to process your claim. If someone, other than you or your insurance, should require copies of your files, we will need a written authorization from you for release of this information to that person.

I have been informed of the policies by which my information is used and transmitted. I hereby authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to AAA Hearing for services rendered. Payment is expected at the time of service. However, if AAA Hearing bills my insurance I agree that should the amount paid by my insurance be insufficient to cover the entire medical expense or my insurance company does not remit benefits within 60 days, I will be responsible to AAA Hearing for payment of the entire balance.

Signature_____Date_____

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name:_____ Date of Birth: _____

I acknowledge that I received a copy of AAA Hearing's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, the website and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

- My "protected health information" (PHI) means health information (audiograms), including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health insurance plan, my employer or a health care clearing house.
- This Notice informs me how AAA Hearing will use my health information for the purposes of my treatment and/or payment for my treatment.
- AAA Hearing will also use and share my health information as required/permitted by law.
- I consent to AAA Hearing use of my PHI for purpose of delivering relevant product and/or technology marketing communication to me. I acknowledge that provider may receive financial remuneration from the manufacture in connection with such communications

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| Signature of patient or personal representative | Date |