PATIENT INFORMATION FORM

3059 Walnut St • Boulder • **303.443.5085**
300 Nickel St, Ste 15 • Broomfield • **303.465.4327**
2770 Arapahoe Rd, Ste 126 • Lafayette • **303.665.0454**

Family HEARING
— Since 1963 —

Date _____

First Name _____

Middle Name _____

Last Name _____

DOB _____

If patient is under age of 18, responsible party must complete remainder of this section.

Name of Responsible Party _____

DOB _____

Home Phone # _____

Cell Phone # _____

Work Phone # _____

Patient SSN _____

Sex:

- ○ Male
- ○ Female
- ○ Not Specified

Gender:

- ○ Man
- ○ Woman
- ○ Nonbinary/Other
- ○ Not Specified

Address Line #1 _____

Address Line #2 _____

City _____

State/Province _____

Postal Code _____

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Secondary Address _____

Preferred Method of Contact

- ○ Home Phone #
- ○ Cell Phone #
- ○ Work Phone #
- ○ Email
- ○ Mail

Age _____

Occupation _____

Marital Status

- ○ Married
- ○ Single
- ○ Partner
- ○ Widowed
- ○ Legally Separated
- ○ Other

Partner Name _____

Emergency Contact _____

Phone # _____

Relation to Patient _____

Primary Care Physician _____

Phone # _____

How did you hear about us?

- ○ Mail
- ○ Newspaper ad
- ○ Promotional call
- ○ Radio
- ○ Insurance
- ○ Yellow pages
- ○ Sponsored event
- ○ Health/senior fair

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- ○ Online
- ○ Employer
- ○ Referred by friend
- ○ Referred by physician
- ○ Other

Additional Comments

Reason for Appointment _____

We strive to provide a convenient location with ample parking, and we expect our staff to always be professional, courteous, and helpful. So that we may provide you the highest level of service, please rate your experience of 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?

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Insurance Information

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

Below are permissions and privacy practices that are standard in most health care settings. Please read and sign. Should you have questions about the details concerning any of the bulleted items, please refer to our Notice of Privacy Practices that is also included in this bundle. It clearly defines what each of these agreements are.

- I give permission to my AudigyCertified™ practice to release information, verbal and written (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 my AudigyCertified practice to contact me for all purposes related to my visit, including marketing-related correspondence, via email, voicemail, and text. I further understand that I can revoke my authorization to receive correspondence via email, voicemail, and text by providing written notification to my AudigyCertified practice.
- I authorize my AudigyCertified practice to use and release my protected health information, i.e., my contact information, for marketing related to hearing care products or services.
- I understand that the practice may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described. I understand that this marketing authorization is in effect until a revocation is received by the practice.
- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
- 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 this information is true and correct to the best of my knowledge, and I hereby give my hearing care provider permission to treat my concerns.
- I authorize Family Hearing to take audio or video recordings of my treatment for training and security purposes. Any recordings of this nature will not be considered part of my medical health record. I understand that my ability to receive treatment is not conditioned on my authorization to be recorded, and that I may revoke this authorization at any time by providing a written request to Family Hearing. I further agree that any recordings made prior to a revocation that were made in reliance on such authorization may be retained and shall not constitute a breach of my rights to confidentiality.

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