GROSSE POINTE AUDIOLOGY

INTAKE FORM

PATIENT INFORMATION

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Name:_____ Date:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone #:_____ Cell Phone #:_____

Work Phone #:_____ Is it ok to call you at work? ☐ Yes ☐ No
If yes, is it ok to say it is Grosse Pointe Audiology calling? ☐ Yes ☐ No

Date of Birth:_____ Age:_____ E-Mail:_____

Referred By:_____

Primary Care Physician:_____ Phone Number_____

Address:_____

CONTACT PERSON

☐ Spouse ☐ Relative_____ ☐ Friend ☐ Other

Name:_____

Home Phone #:_____ Cell/Work Phone #:_____
Is it ok to call at work? ☐ Yes ☐ No

HEARING AID INFORMATION

Have you ever worn hearing aids? ☐ Yes ☐ No

Where were your hearing aids from? _____

Who is the Manufacturer of your hearing aids? _____

How old are your hearing aids? _____

Comments: _____

SIGNATURE ON FILE

I authorize use of this form on all my insurance submissions.

I understand that I am responsible for my bill.

I authorize you to act as my agent in helping me obtain payment from my insurance company.

I permit a copy of this authorization to be used in place of the original.

I hereby authorize Grosse Pointe Audiology, LLC, to release to my insurance company any information acquired in the course of my examination or treatment.

I authorize my insurance company to pay my insurance benefits to Grosse Pointe Audiology, LLC, for service rendered and I am responsible for any unpaid balance.

Name:_____ Date:_____

Signature:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

☐ By checking this box and signing below, I acknowledge that I received a copy of Grosse Pointe Audiology's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website and that any revised Notice of Privacy Practices will be made available.

_____ _____

Printed name of patient or personal representative Date

_____ _____

Signature of patient or personal representative Date

GROSSE POINTE AUDIOLOGY

FINANCIAL POLICY

Grosse Pointe Audiology, LLC believes that part of good hearing healthcare practice is to establish and communicate our financial policy. We are dedicated to providing the best hearing healthcare to you.

INSURANCE: As a courtesy we will verify your benefits with your insurance company. A quote of benefits is not a guarantee of payment. Your insurance claim will be processed according to your plan. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable amount of time, you will be billed. If we later receive payment from your insurer, we will refund you any overpayment. If our doctors are not listed in your plan's network, you may be responsible for partial or full payment.

Your signature below acknowledges your part in understanding the financial policies of Grosse Pointe Audiology.

_____ _____

Patient/Guardian Signature Date