GROSSE POINTE AUDIOLOGY

PATIENT INTAKE FORM

PATIENT INFORMATION

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Father ☐ Sister ☐ Brother ☐ Child

Name _____ Today's Date _____

Street address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Preferred way to contact you ☐ Home ☐ Cell ☐ Work ☐ E-mail Check all that apply

Date of Birth _____ Age _____ E-Mail _____

Referred By _____ Primary Care Physician _____

PCP Phone Number _____ PCP Address _____

CONTACT PERSON

Grosse Pointe Audiology may contact the following people listed below for communication about my medical care.

CONTACT NAME	CONTACT NAME
RELATIONSHIP TO YOU	RELATIONSHIP TO YOU
HOME PHONE	HOME PHONE
CELL PHONE	CELL PHONE

PATIENT SIGNATURE _____

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.

Printed name of Patient or Personal Representative _____ Date _____

Signature of Patient or Personal Representative _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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.

I authorize Grossse Pointe Audiology to send me educational and/or marketing information on the products and services offered by Grosse Pointe Audiology. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

Printed name of Patient or Personal Representative _____ Date _____

Signature of Patient or Personal Representative _____ Date _____

ACKNOWLEDGEMENT OF FINANCIAL POLICY

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.

Printed name of Patient or Personal Representative _____ Date _____

Signature of Patient or Personal Representative _____ Date _____