

Resonance Audiology and Hearing Aid Center, LLC

.Hearing.Life.

Welcome to the Resonance Audiology, we want to provide excellent hearing care to you. Please tell us a little about yourself by completing as much as possible on both sides of this form.

How did you hear about us? _____

PERSONAL INFORMATION:

PATIENT'S NAME _____
FIRST MIDDLE LAST

MAILING ADDRESS _____
CITY STATE ZIP

TELEPHONE (HOME) _____ (WORK) _____

DATE OF BIRTH _____ AGE _____ MALE _____ FEMALE _____ MARITAL STATUS _____

FULL NAME AND PHONE NUMBER OF PRIMARY CARE PHYSICIAN _____

NAME & TELEPHONE OF NEAREST RELATIVE _____

EMAIL ADDRESS: _____ May we contact you via email? YES _____ NO _____

INSURANCE INFORMATION - PLEASE READ AND SIGN/INITIAL:

DISCLAIMER: As a professional courtesy, we will submit your claim to your insurance provider, but this does not guarantee their payment. You accept responsibility for co-pay, deductibles, or uncovered procedures. If you have a hearing aid benefit, you may be required to pay for your hearing aid upfront. Upon receipt of payment from your insurance company, we will reimburse you for the amount that the insurance company covered/paid. **PLEASE INITIAL:** _____

PLEASE BRING YOUR INSURANCE CARD(S) WITH YOU TO BE COPIED FOR YOUR FILE.

If health insurance is not in your name, please provide the following information:

Name of insured _____ Relationship to patient _____

Insured's Date of Birth _____ Insured's Employer _____

I hereby authorize Zoe Horan, Au.D. and her associates to furnish information to my insurance carrier concerning my illness and treatment, and I hereby assign to her all payments for services rendered to my dependents or myself. I understand that I am responsible for payment.

SIGNATURE _____ DATE _____

PLEASE READ AND SIGN/INITIAL:

In order to keep your medical file up to date, we will be happy to provide your physician with a copy of our audiological findings. **Please initial ONE** →
Send a copy to my physician _____ (initial)
DO NOT send a copy to my physician _____ (initial)

Privacy Practice Notice: According to government law, we are required to make available to you a copy of our privacy practice notice. Your signature below acknowledges your receipt of such:

SIGNATURE _____ DATE _____

