



- Neuro-Audiology Consultants
- Miami Hearing and Speech Center
- Audiology Consultants of Boynton Beach

PATIENT INFORMATION

Name of Patient _____ <input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Divorced <input type="radio"/> Widowed Spouse Name _____ DOB _____ Address _____ City _____ State _____ Zip _____ Home# _____ Cell# _____ Work# _____ Email _____	Age _____ Date of Birth _____ Sex <input type="radio"/> M <input type="radio"/> F Weight _____ Driver's License No. _____ Social Security No. _____ Patient Occupation _____ Employer Name _____ Address _____ City _____ State _____ Zip _____
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Emergency Contact Name (that does not reside with you) _____	Phone _____
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If patient is a minor, please complete this section.

Name of Responsible Party _____			
Address _____			
City _____	State _____	Zip _____	

Mother's Work Phone _____	Father's Work Phone _____
Mother's Name _____	Father's Name _____
Address _____	Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____

If parents are divorced, who has legal custody? Mother Father Both Other

Responsible Party (if other than patient).

Name _____ DOB _____	Social Security No. _____
Address _____	Driver's License No. _____
City _____ State _____ Zip _____	Employer _____
Home Phone () _____	Address _____
Work Phone () _____	City _____ State _____ Zip _____

Family Doctor _____ Address _____ City _____ State _____ Zip _____ Telephone () _____ Fax () _____	Referred By _____ Address _____ City _____ State _____ Zip _____ Telephone () _____ Fax () _____
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INSURANCE INFORMATION

Records Release

This must be signed if any insurance is to be filled by you or us.

I hereby authorize Neuro-Audiology Consultants/Miami Hearing & Speech Center/Miami Hearing Aid Center/Audiology Consultants of Boynton Beach to release to my insurance company any information acquired in the course of my examination or treatment.

Signed _____ Date _____

Assignment of Benefits

This must be signed if we are filing to you insurance company for payment

I authorize my insurance company to pay my medical benefits to Neuro-Audiology Consultants/Miami Hearing & Speech Center/Miami Hearing Aid Center/Audiology Consultants of Boynton Beach for services rendered.

I understand that I am responsible for any unpaid balance.

Signed _____ Date _____

Insurance Waiver

This must be signed by (or on behalf of all patients).

I understand that services provided to me may not be a covered benefit as defined by my insurance company. I agree to be personally responsible for payment for the services rendered. I also agree to pay any co-pays and/or deductibles as required by my insurance company.

Signed _____ Date _____

Notice of Privacy Practices

This must be signed by (or on behalf of all patients).

I have been given the opportunity to read and receive a copy of the Notice of Privacy Practices (NPP) of Neuro-Audiology Consultants, Audiology Consultants of Boynton Beach, Miami Hearing & Speech Center & Miami Hearing Aid Center. The NPP provides detailed information about how the practice may use and disclose my confidential information.

The provider reserves the right to change the privacy practices that are described in the NPP. I understand that a copy of any Revised Notice will be provided to me or made available in the office.

Signed _____ Date _____

Primary Insurance Information

Subscriber's Name _____	Insurer _____
Social Security No. _____	Address _____
ID# _____ Group# _____	City _____ State _____ Zip _____
Date of Birth _____	Phone No.() _____

Do you have secondary insurance? Yes No

If yes, the receptionist needs information regarding your secondary insurance so that your claim can be submitted appropriately.