PATIENT INFORMATION

150 NACOOCHEE AVENUE • ATHENS, GEORGIA 30601
(706) 546-5689 • FAX (706) 543-7675

Patient Name: Last _____ First _____ MI _____

Nickname: _____

S.S. #: _____ Date of Birth: _____

Male _____ Female _____ Marital Status: S M D W (circle one)

Address: _____ Spouse: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer and/or Retired: _____

Work Phone: _____ E-mail Address: _____

** RESPONSIBLE PARTY: Full Name: _____

Relationship to Patient: _____

Birth Date: (must have for primary holder) _____

Address: _____

Phones: Home _____ Cell _____ Work _____

Primary Physician: _____ Phone #: _____

Primary Insurance: _____ Policy Holder: _____

Secondary Insurance: _____ Policy Holder: _____

Emergency Contact Name: _____

Their relation to you: _____

Their Phone: _____

Payment of all Co-pays, deductibles, and any other patient responsibility fees are due when services are rendered. Necessary forms will be completed to expedite insurance carrier payments. I hereby assign to Georgia Hearing Center all payments for services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance. I further agree in the event of non-payment, to bear the cost of collection, and/or court cost and reasonable legal fees should this be required.

_____ _____

Signature: Date:

** MUST BE COMPLETED.

I give permission for Georgia Hearing Center to release information, verbal and written (contained in my medical record and other related information), to my primary care physician, related healthcare providers, assignees and/or beneficiaries and all other related persons.

_____ Initial ONLY IF refusing permission to release medical records to other than referring provider.

I acknowledge that I have received and reviewed the Health Insurance Portability and Accountability Act (HIPAA) policy of Georgia Hearing Center.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services and products rendered.

I wish to be contacted in the following manner:

- ❑ Phone _____
- ❑ Email _____
- ❑ Mail _____

How did you hear about Georgia Hearing Center?

- ❑ Physician Referral (If yes, name of physician.) _____
- ❑ Friend ❑ Family ❑ Employer ❑ Internet Search ❑ Previous Patient
- ❑ Other, please specify _____

Did you visit our website georgiahearingcenter.com before your visit today? ❑ Yes ❑ No

I have read all the information on this sheet, completed the above answers, and certify that this information is true and correct to the best of my knowledge and hereby give Georgia Hearing Center permission to treat my concerns.

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

GEORGIA HEARING CENTER

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