GAVIN AUDIOLOGY AND HEARINGAIDS

Patient Name:_____ **Sex:**_____ **DOB**_____ **Age:**_____
First MI Last

Mailing Address:_____
Street City State Zip

Home Phone #:_____ **Cell #:**_____ **Work/Other #:**_____

Email Address: _____ May we contact you via email? ○YES ○NO

Preferred Method of Contact: ○ Home ○Work ○Cell ○Email ○Mail

Pt. Social Security #:_____ **Occupation:** _____ ○Full time ○Part Time ○Retired

PRIMARY Insurance Company:_____ **Insurance ID#:**_____
Referral Required?:_____ **Copayment:**_____
Policy Holder:_____ **Policy Holder DOB:**_____

SECONDARY Insurance Company:_____ **Insurance ID#:**_____
Policy Holder:_____ **Policy Holder DOB:**_____

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-payment, deductibles, or uncovered procedures. Your insurance must be on file at the time of your appointment. PLEASE INITIAL: _____

I hereby authorize Gavin Audiology and Hearing Aids to release any medical or other information to in my insurance carrier necessary to process my claim and I hereby assign all payment of authorized benefits be made on my behalf to Gavin Audiology and Hearing Aids. PLEASE INITIAL:_____

I understand that if I am seen without a referral from my primary care physician and my health plan required that I obtain that referral, then my health plan may not cover the changes, costs or expenses of my care from Gavin Audiology and Hearing Aids and in that case I will be responsible for the total balance. PLEASE INITIAL:_____

Primary Care Physician:_____ **Phone Number:**_____
Address:_____ **Fax Number:**_____
_____

Current Medications (prescription, OTC, herbals/vitamins/minerals, nutritional supplements**)**
Medication:_____ **For:**_____ **Since:**_____ **Dose/Freq/Route:**_____
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Do you smoke? ○ Yes ○No

Have check any of the following that you currently have or have had in the past:

○Pacemaker	○Vision Loss	○Peripheral Neuropathy	○Diabetes	○Stroke/TIA
○Measles/Mumps	○Ear Infections	○High Blood Pressure	○Ear Trauma	○Head Injury
○Depression	○Multiple Sclerosis	○Parkinson's Disease	○Dementia	○Cancer
○Ear Surgery	○Heart Condition	○Neurological Disorders	○ Migraines	○MRI/CT scan

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 this notice:
Patient Name:_____ Patient Signature:_____
Relationship to Patient:_____ Date: _____

Patient Consent Form- HIPPA

I understand that under the Health Insurance Portability & Accountability Act of 1966 (HIPPA), I have certain rights to privacy regarding my protected health information, I understand that this information can and will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly

*Obtain payment from third party payers

*Conduct normal health care operations such as quality assessments and physician certifications.

I have been informed of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address stated to obtain a current copy of the Notice of Privacy practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment and payment of health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____ Patient Signature:_____
Relationship to Patient:_____ Date: _____

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