EXPERT HEARING CARE

Patient Profile and Consent Form

Patient's Legal Name: _____

Date of Birth: _____/_____/_____ (MM / DD / YEAR) Sex: ☐ M ☐ F Marital Status: _____

Mailing Address: _____
Street City State Zip

	Can we leave a message?	Primary Phone
Home Phone: _____	☐	☐
Cell Phone: _____	☐	☐
Work Phone: _____	☐	☐

Email Address: _____

Occupation: _____

Current Employer: _____

Preferred Form of Contact

☐ Phone ☐ Text ☐ Email

If "Text", we will need your mobile phone carrier:

☐ AT&T ☐ Sprint ☐ T-Mobile
☐ Verizon ☐ Other _____

Primary Insurance Information:

If the patient is not the primary insurance holder, fill out the following:

Primary Subscriber's Name: _____

Their Relationship to patient: _____

Their DOB: _____/_____/_____ (MM / DD / YEAR)

Secondary Insurance Information:

If the patient is not the primary insurance holder, fill out the following:

Secondary Subscriber's Name: _____

Their Relationship to patient: _____

Their DOB: _____/_____/_____ (MM / DD / YEAR)

Primary Care Physician: _____

Referring Physician: _____

Family Contact Information:

Name: _____
First MI Last

Relation: _____ DOB*: _____/_____/_____ (MM / DD / YEAR)

*(date of birth required for ID purposes when patient not present)

Phone number: _____

Can we communicate results? ☐ Yes ☐ No

May we leave a message? ☐ Yes ☐ No

May we contact the person listed above in case of an emergency? ☐ Yes ☐ No

May this person pick up or drop off your hearing devices? ☐ Yes ☐ No

How did you hear about us? Please check all that apply.

☐ Social Media ☐ Insurance provider
☐ Family Member ☐ Website
☐ Physician ☐ Direct mail
☐ Google/Internet search ☐ Newspaper Ad
☐ Office Door Sign ☐ Billboard
☐ Friend/current patient referral

Who can we thank for the referral? _____

_____

(please continue on next side)

Please read and acknowledge by signing below:

- I certify to the accuracy of the above information.
- I understand that I am personally responsible for the amount of charges regardless of insurance coverage and authorize the release of any medical or other information necessary to process claims.
- I understand my insurance benefit will be checked as a courtesy, however, I am responsible for understanding my insurance coverage.
- I further authorize payment of medical benefits directly to the undersigned provider.
- I hereby acknowledge that I received or have access to the Advanced Hearing Care, LLC Notice of Privacy Practices. This is made available on our website, at our office, or can be sent via email.
- I understand that if I am unable to make my appointment, I need to call and reschedule 24 hours prior to my appointment. I also understand if I arrive late for my appointment, I may be asked to reschedule or be worked into the day. **If I do not show for my appointment and do not call to the office to cancel my appointment in advance, I will be considered as a no-show and will be charged a $25 no-show fee.**
- I understand if my check is returned for non-sufficient funds, I will be responsible for paying a $25 fee in addition to re-issuing payment for a returned check.
- **Consent for Treatment:** I, the undersigned, voluntarily agree to the tests, procedures, and/or treatments which the provider deems necessary and which are administered to or performed on me under the direction of the provider or his/her designee.
- **Consent of Treatment of Minors**: I, the undersigned, understand that a minor child (17 and under) must have my consent to be treated. I understand that I must be present at each appointment for any child aged 14 and under. If the child is between the ages of 15 and 17, I understand I must send a note with the child to the appointment for consenting treatment. The notes must contain the date, a statement of consent, and printed legal name, and my signature. Further, I understand that consent for treatment does not alter the legal requirements for confidentiality. I also understand that New Mexico State Law provides for minors to seek care without parental consent for certain medical issues.

_____ _____

Print Legal Name Signature

_____ _____

Relationship to Patient Date