HEARING AID SERVICES of Mississippi

PATIENT INFORMATION

Patient Name:_____ Today's date:_____

Last First MM/DD/YY

Gender: ☐ M ☐ F Marital Status: ☐ Married ☐ Single Date of Birth:_____

Home Phone: _____ Work Phone:_____

Cell Phone: _____ E-mail:_____

Occupation (Current or prior):_____

Mailing Address:_____

_____

Emergency Contact:_____ Phone:_____

Relationship to patient:_____

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

☐ Mail ☐ Website ☐ TV ☐ Referred by physician:_____

☐ Newspaper ☐ Yellow pages ☐ Employer ☐ Referred by friend:_____

Health Insurance Portable Privacy Act (HIPPA) Agreement

☐ I give permission to my hearing healthcare professional to release information—verbal and written, contained in my medical records and other documents—to my insurance company, rehab, nurse, case manager, attorney, employer, healthcare providers, assignees and/or beneficiaries and all other relevant persons.

☐ I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services rendered or purchases made. I understand that I can return the product within 30 days for a money back guarantee

☐ I have read all the information on this sheet, have provided the requested information, certify this information is true and correct to the best of my knowledge, and hereby give my hearing healthcare professional permission to treat my condition.

Signature:_____ Date:_____