Audiology Associates of South Florida Inc.

PATIENT INFORMATION

NAME OF PATIENT: _____ DATE:_____
LAST NAME FIRST NAME M.I.

ADDRESS: _____
CITY STATE ZIP CODE

HOME/CELL PHONE NUMBER DATE OF BIRTH SEX MARITAL STATUS

REFERRAL SOURCE or DOCTOR'S NAME CHIEF COMPLAINT

INSURANCE INFORMATION: _____
RESPONSIBLE PARTY=S NAME RELATIONSHIP TO PATIENT

SOCIAL SECURITY # email address

PRIMARY INSURANCE COMPANY ID NUMBER GROUP NUMBER

ADDRESS PHONE NUMBER

SECONDARY INSURANCE ID NUMBER GROUP NUMBER

ADDRESS PHONE NUMBER

CONSENT FOR TESTING:

The undersigned hereby consents to any testing procedures or services rendered the patient by Audiology Associates of South Florida. I also acknowledge that no guarantee or warranty has been made by Audiology Associates of S. Florida as to the results of any testing which may be performed.

RELEASE OF INFORMATION TO AGENCIES OR PHYSICIANS:

Audiology Associates of S. Florida is hereby authorized to release all or any part of the medical record of the patient named on this registration to such insurance companies or agencies as may be concerned with the results and payment of testing and interpretation. I, the undersigned hereby authorize Audiology Associates of S. Florida to release any pertinent information concerning the patient to:

ASSIGNMENT OF INSURANCE BENEFITS :

I hereby authorize payment directly to Audiology Associates of S. Florida and/or Roberta Randel, M.A. of the medical benefits under the insurance coverages identified on the information sheet and any others which may be payable to me for all services rendered. I understand I am financially responsible for all charges not paid under this assignment. I authorize the use of this signature on all my insurance submissions whether manual or electronic. If collection becomes necessary, I agree to pay all costs including attorney's fees.

Signature of Patient / Parent / Guardian Date