Elkhart Audiology Rehab Patient Registration

We are pleased you chose our office for your hearing health care! Please let us know if you have any questions, or if there is something we can do to better meet your needs.

Patient Name: _____ Date of Birth: _____ Age:_____

Gender: M / F Marital Status: Single / Married / Other Social Security # _____

Mailing Adress_____
Street City State Zip

Home Phone_____ Cell Phone_____

Work Phone _____ E-mail _____

May we leave a message on you answering machine or cell phone? Yes / No

Preferred Method of Contact: Home Phone__ Cell Phone__ Work Phone__ E-mail__ Text__

Parent/Spouse/POA/ Alternate Contact Person:_____

Alternate Billing Address: _____

Alternate/Emergency Phone Number: _____ Relationship _____

Employer or Previous Employer_____ Occupation_____

Primary Care Physician _____

How was the Patient referred to our office? Physician ___Friend ___ Relative ___ Website ___
Phone Book ___ Advertisement ____ Other _____
Please list the referral name so we may thank them_____

Insurance Information: *Please allow our staff to make a photocopy of your photo identification and insurance cards*.

Payment is Required at the Time of Service, We accept Cash, Check and Credit Cards

Assignment of Benefits: I hearby authorize direct payment of benefits to Elkhart Audiology Rehab, LLC for services rendered. I understand some products and services may not be covered by insurance and understand I am responsible for any charges not covered by insurance. Payment is expected within 30 days of service.
Authorization to Release Information: I hearby authorize Elkhart Audiology Rehab, LLC to release any audiologic/medical/procedure information that may be necessary for continued hearing health care with another professional or for processing an insurance claim. **Privacy Policy**: Our office will take reasonable effort to insure your patient information is kept private. **Ethical Business Practices:** We will not sell your personal health or contact information to any other entity. However, you may receive certain types of communication that are sponsored or reimbursed by a third party whose products, services or therapies, including hearing instruments, which are promoted in the communication. By signing below you are in agreement that you have been informed and agree to these practices. If you wish to revoke this agreement or any part of it, it must be done in writing.

_____ _____
Signature of Patient or Legal Guardian Date