Elkhart Audiology Rehab 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.

Name: _____ Date of birth: _____ Age: _____
FIRST MIDDLE INITIAL LAST

Gender: □M □F Marital Status: □Married □Single □Widow/Widower SS#: _____

Mailing Adress_____
Street City State Zip

Home Phone_____ Cell Phone_____

Work Phone _____ E-mail _____

Preferred Method of Contact: □Home Phone □Cell Phone □Work Phone □E-mail □Text**

****If texting is preferred**, who is your phone carrier? _____

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

Alternate Contact Person : _____ Relationship : _____

Alternate Contact Address: _____Phone: _____

**Should the alternate contact be used for billing or phone calls ? □Billing □Calls □Both

POA (Power of Attorney) : _____

Primary Care Physician: _____Insurance Provider: _____

Employer (for Insurance if applicable): _____

How were you referred to our office? □Physician □Internet search □Website □Facebook
□Newspaper □Phone book □TV **__Referral name__** so we may thank them_____

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

Assignment of Benefits: I hereby 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 or a $10.00 late fee will be applied.

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

Authorization to Release Information: I hereby 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 ensure 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 communications 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 agree 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

(Revised 06-16-2022)