PROFESSIONAL HEARING SERVICES

Demographics & Consent Form

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Name: _____ DOB: _____ Age: _____
Last First MI M/D/Y

Address _____ City _____ State: _____ Zip _____

Home # _____ Work # _____ Cell # _____

Email _____ May we leave a message? **Y** □ **N** □ Sex: M □ F □

Which method is best to reach you? Home □ Work □ Cell □ Email □ Text □ Marital Status: M □ S □ W □ D □

Occupation _____ Employer _____ Retired **Y** □ **N** □
(If retired, prior occupation)

Please list any person(s) that we may discuss your hearing health or insurance information with:

Name:	**Relationship:** (Spouse, child, POA)	**Contact Info:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have a POA? **Y** □ **N** □ Name _____ Phone _____
(Power of Attorney)

***ANTHEM/ BCBS MEMBERS PLEASE PRESENT YOUR INSURANCE CARD**
For insurance purposes (**If policy holder is different than self**):
Policy Holder Name _____ Date of Birth _____
Employer _____

PRIMARY CARE PHYSICIAN: Name _____ MD □ DO □ NP □ PA □

City/State _____ **Phone #** _____ **Fax#** (317)705-7180

How did you hear about us (**check all that apply**)? Website □ Google Reviews □ Facebook □ Bulletin □ Insurance□

□ Friend _____ □ Physician _____

□ Other _____ □ Angie's List Monthly Magazine/Angie's List website

**********PLEASE READ CAREFULLY AND SIGN BELOW**********

- I give permission to Professional Hearing Services, Inc. to release information, verbal and written (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.
- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability (HIPAA) policy of this office.
- I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge.
- I hereby give Professional Hearing Services, Inc. permission to provide audiological evaluation and treatment of my concerns.
- I understand and agree that, regardless of my insurance status, I am ultimately responsible for my account balance.
- I authorize payments of medical benefits to be paid directly to Professional Hearing Services.
- I accept full responsibility of all services and charges not paid for by my insurance company or benefit plan.
- I accept full responsibility for all charges in the event that I have no insurance or benefits. Charges 30 days past due are subject to late fees.

I have read and understand all the above information.

Signature _____ Date _____