Dx:_____

Professional Hearing Services

Suzanne O'Connor, Au.D.
Owner/Doctor of Audiology

Amanda Rosinko, Au.D
Doctor of Audiology

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

Address_____ City_____ 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, etc.)	**Contact Info:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

PLEASE PRESENT YOUR INSURANCE CARDS AND DRIVER'S LICENSE FOR PHOTOCOPYING
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**#_____

How did you hear about us (**check all that apply**)? Website □ Employer □ Yellow Pages □ Ins Co. □ Ad □

□ 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 authorize Professional Hearing Services, Inc. to use and release my protected health information for marketing related hearing care products or services. I understand that the practice may receive financial remuneration in exchange for making communication from or on behalf of the third party whose product or service is being described. I understand that this marketing authorization is in effect until a revocation is received by the practice.
- 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, and I hereby give Professional Hearing Services, Inc. permission to treat my concerns.
- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.

I have read and understand all the above information.

Signature_____ Date_____