PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____

Address (Street) _____

City _____ ST: _____ Zip: _____

Primary Phone #:_____ Birth Date:_____ Age:_____ Male: _____ Female: _____

Social Security #:_____ Employer _____

Marital Status: Married_____ Divorced____ Single_____ Separated_____ Widowed_____

Spouse's Name: _____ Parent's Name(s) (if pt. is under 18) _____

Emergency Contact: _____ Phone #_____

Primary Physician (Full Name): _____ Phone #_____

How did you hear about Audiology of Tulsa? (Please check one):

_____ By Physician (Name)_____

_____ By Friend/Family _____Online _____Other_____

INSURANCE INFORMATION

This area must be completed carefully and entirely for proper submission of your insurance claim. Failure to do so could result in non-payment of claim. We must also make a copies of the cards and a photo ID.

Primary Insurance: _____

Phone#: _____ Group ID#: _____Insurance ID#: _____

Are you the primary cardholder? ____Yes ____No **If no, please complete the following. If yes, leave blank.**

Primary Cardholder _____ Birthdate_____Relationship to Patient:_____

Primary Cardholder's employer: _____

Address of Cardholder if Different from Patient: _____

Secondary Insurance: _____

Phone #: _____ Group ID#: _____Insurance ID# _____

Are you the primary cardholder? ____Yes ____No **If no, please complete the following. If yes, leave blank.**

Primary Cardholder: _____Birthdate:_____ Relationship to Patient: _____

Primary Cardholder's employer:_____

Address of Cardholder if Different from Patient: _____

Please see page 2

Audiology of Tulsa, PLLC 918-745-9052

4564 S Harvard Ste A – Tulsa OK 74135-2918

SIGNATURE AUTHORIZATION

Audiology of Tulsa, PLLC is a privately owned company and all scheduling and billing will be conducted through the corporation. I authorize direct payment of any medical benefits for services performed at Audiology of Tulsa, PLLC, be sent directly to the office. I understand that I am ultimately responsible for the balance on my account for any professional services rendered. Audiology of Tulsa, PLLC will be happy to assist me with filing insurance, but I understand it is my responsibility to contact my insurance carrier to determine if Audiology of Tulsa, PLLC is in my specific network. I authorize Audiology of Tulsa, PLLC to release any information relating to the service obtained here and those services related to my treatment to other professionals and insurers as may become necessary.

I authorize Audiology of Tulsa, PLLC and its staff, to communicate with me and other authorized health care providers involved in my care about any aspect of my health and medical care by means of electronic mail, or Facsimile. I accept the risk of loss of privacy of confidential medical information associated with communication by electronic mail and nonetheless, agree to its use. Audiology of Tulsa, PLLC shall not be liable for any type of damage or liability arising from or associated with loss of confidentiality due to communication by electronic mail. or faxing. The information authorized for release may include information which may be considered a communicable or venereal disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS).

I understand that it is my responsibility to notify Audiology of Tulsa, PLLC if I am unable to keep my scheduled appointment. Failure to give appropriate notice of cancellation may result in a "no show" fee for which I will assume responsibility, I also permit a copy of this authorization to be used in place of the original. I have read and agree to the above Signature Authorization section and comprehend that it will remain in effect until revoked by me in writing.

HIPAA NOTIFICATION AND RESPONSIBILITY

I affirm that I have been given the opportunity to read a copy of the HIPAA Notice of Privacy Procedures.

Patient Name (PLEASE PRINT) _____

Signature: _____

Relation (if other than patient) _____

Date: _____

Patient Authorization of Disclosure

May we contact you and leave messages at_____? _____Yes _____No

May we contact you by email? ___No ___Yes Please list: _____

Please list any other contact information (such as additional phone numbers):

_____

_____

_____

_____

In a further effort to protect your health information and the confidentiality of your healthcare, we ask that you designate below to whom the staff at may discuss and release your healthcare and scheduling needs as well as billing issues that may arise.

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Patient Signature:_____ Date:_____