AUDIOLOGY OF TULSA

PATIENT REGISTRATION

TO BE COMPLETED BY PATIENT OR LEGAL GUARDIAN

PATIENT LEGAL NAME: (LAST) _____ (FIRST) _____ (MI) _____

HOME ADDRESS: _____

PHONE: _____ HOME WORK OTHER PHONE: _____ HOME WORK OTHER

BIRTHDATE: _____ AGE: _____ PATIENT SOCIAL SECURITY: _____

MARITAL STATUS: MARRIED SINGLE OTHER EMPLOYER: _____

GENDER: M F OTHER EMAIL: _____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

NAME: _____ POLICY HOLDER DOB: _____

RELATIONSHIP TO PATIENT: _____ IS ADDRESS THE SAME? Y N

ADDRESS: _____

EMPLOYER: _____ SOCIAL SECURITY: _____

INSURANCE

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 COPIES OF CARDS AND PHOTO ID.

PRIMARY INSURANCE: _____

MEMBER ID #: _____ GROUP #: _____

POLICY HOLDER NAME: _____ POLICY HOLDER DOB: _____

RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE: _____

MEMBER ID #: _____ GROUP #: _____

POLICY HOLDER NAME: _____ POLICY HOLDER DOB: _____

RELATIONSHIP TO PATIENT: _____

HOW DID YOU HEAR ABOUT AUDIOLOGY OF TULSA? _____

PATIENT INFORMATION MAY BE RELEASED TO THE FOLLOWING: _____

PRIMARY CARE PHYSICIAN: _____

AUTHORIZATION FOR RELEASE OF INFORMATION AND INSURANCE ASSIGNMENT

I HEREBY AUTHORIZE AUDIOLOGY OF TULSA, PLLC TO RELEASE ANY AND ALL INFORMATION CONCERNING MEDICAL TREATMENT RENDERED TO THE PATIENT NAMED HEREIN TO ANY INSURANCE COMPANY OR GOVERNMENTAL AGENGY MAKING PAYMENTS FOR MEDICAL SERVICES RENDERED AND TO ANY DOCTORS OR HELATH CARE PROVIDER WHO ARE INVOLVED IN THE PATIEN'TS CARE. "THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY BE CONSIDERED A COMMUNICABLE OR VENERAL DISEASE INCLUDING BUT NOT LIMITED TO HEPATITIS, SYPHILLIS, GONORRHEA, HUMAN IMMUNODEFICIENCY VIRUS AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)". I ALSO AUTHORIZE ASSIGNMENT OF ALL INSURANCE BENEFITS TO AUDIOLOGY OF TULSA, PLLC.

HIPAA NOTIFICATION AND RESPONSIBILITY

I AFFIRM THAT HAVE BEEN GIVEN AND READ A COPY OF THE HIPAA NOTICE OF PRIVACY PROCEDURES. I UNDERSTAND THAT I AM RESPONSIBLE TO PAY ALL MEDICAL SERVICES NOT COVERED BY AN AUTHORIZATION BETWEEN MY PHYSICIAN AND MY INSURANCE COMPANY.

X SIGNATURE _____ **DATE** _____