Covington Hearing

PATIENT INFORMATION

Name: _____ Preferred (Nick) Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home _____ Cell _____ Work _____

Date of Birth: _____ /_____ /_____ Age: _____ Last 4 digits Social Security #: _____

Email address: _____

Marital Status: (please circle) Single Married Widowed Divorced

Spouse/Partner Name: _____ Parent/Guardian Name: _____

Primary Care Physician: _____ Phone: _____

Race: (please circle) American Indian Asian Black Hawaiian White Decline

Ethnicity:(please circle) Non-Hispanic Hispanic Decline

Preferred Language: (please circle) English French Hindi Italian Spanish Other Decline

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Emergency Contact Name: _____ Phone #: _____

How did you hear about us?

____Mail ____Newspaper/Magazine Ad ____Website/Social Media ____Friend/Relative/Neighbor

____Health/Senior fair ____Employer ____Sponsored Event ____Insurance ____Physician

Reason for your appointment _____

I authorize Covington Hearing Associates, llc., to release to my insurance company, employer/school and/or referring physician, any information required in the course of my examination and treatment. I also authorize any physician, hospital, or clinic to provide details of my history to Covington Hearing Associates llc. I hereby give consent to the providers of Covington Hearing Associates, llc, for treatment. I hereby assign payment directly to Covington Hearing Associates, llc., for medical benefits payable for these services. Should my claim(s) need an appeal, I authorize Covington Hearing Associates llc., to appeal on my behalf. I understand that I am responsible for payment of services, including supply fees, rendered regardless of Insurance coverage. If a patient is a minor, I am responsible for the payment of services. I also hereby acknowledge that I have received a copy of the financial policy and agree to adhere to all policies stated. Covington Hearing Associates will charge a fee of 25% of the total balance due if my account is turned over to an outside collection agency. I acknowledge that I have been made aware of and can review the Health Insurance Portability Act (HIPPA) policy of this office. By signing below I have read and understand the above.

_____ _____ _____

Patient/Responsible Signature Print Name Date