PATIENT INFORMATION Appointment Date:

Name (last, first, MI):		**DOB**:
(Mr., Mrs., Ms., Dr.)	**Marital status**: single/married/widowed/divorced/partner:	**Spouse/Partner's name**:
Address:		**Language**: **Preferred Pronoun**:
Patient's Home Ph #:	**Work Ph #:**	**Cell Ph #:**
Patient's Email address:		**Primary Care Physician (PCP):**
Alternate Contact: **Relationship:**	**Alternate Contact Phone:**	

IF PATIENT IS A MINOR

Parent A Name:	**Parent A best phone:**	**Parent A email**
Parent A: Address		
Parent B Name:	**Parent B: best phone**	**Parent B email**
Parent B Address		

Primary INSURANCE INFORMATION

Who is the policy through? **Subscriber Name**:	**Relationship to Subsriber**: **Subscriber's DOB:**
Employer:	**Employer City & State:**
Primary Insurance:	**Policy #**

Secondary INSURANCE INFORMATION

Subscriber Name:	**Relationship:**
Employer:	**Employer City & State:**
Secondary Insurance:	**Policy #:**

Is there a third insurance policy? Select one: YES NO.

The insurance information listed above is true to the best of my knowledge. I hereby authorize treatment.

Signature (patient or parent if minor)____

Date____________________

ASSIGNMENT OF BENEFITS: I irrevocably assign to you, my medical provider, all my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the health care carrier. I direct that all reimbursable medical payments go directly to you, my medical provider

I will be responsible for any copay, coinsurance or deductibles as defined by my insurance policy. I understand it is my responsibility to obtain a referral or prior authorization if necessary, for any procedures now or in the future. If a referral or prior authorization was needed for insurance reimbursement and was not obtained, I understand I am responsible for the full payment for the services rendered to me.

SIGNATURE__________________________________ DATE:_____________

RELEASE OF INFORMATION: I understand that HIPAA allows Clarke to obtain medical information regarding my physical condition and *treatment from any other health care provider, including hospitals, diagnostic centers. etc.* and **I specifically authorize such provider(s) to release all such information to you about me**, including medical reports, radiological reports, narrative reports, and any other report or information related to the care I receive in your office.

Additionally, I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates.

(list who we can share your information with: such as, but not limited to your physician, partner or adult child)

1. Name: ________________________________ Phone: ______________________
2. Name: ________________________________ Phone: ______________________
3. Name: ________________________________ Phone: ______________________
4.

USE AND DISCLOSURE: By signing below, I understand that the Clarke Hearing Center has a right to use and disclose my Protected Health Information under specific circumstances as outlined in the HIPAA Notice of Privacy Practices. I understand that I have the right to restrict how my Protected Health Information is used by Clarke if I pay privately or provide written opt out notice for fundraising and/or certain marketing activities (i.e. sale of PHI; where Clarke receives remuneration from third party for marketing activity).

I have read and initialed the above statements. I have been offered any opt out forms that I have requested. I have been offered a Clarke HIPAA Notice of Privacy Practices and encouraged to read same.

SIGNATURE__________________________________ DATE:_____________

Name and Relationship to patient if signed by other:____________________________________