Audiology Group
of Northern Colorado

REGISTRATION INFORMATION

PATIENT'S LAST NAME	FIRST NAME	MIDDLE	SOCIAL SECURITY #

DATE OF BIRTH	SEX (CIRCLE ONE) M/F	MARITAL STATUS (CIRCLE ONE) SINGLE MARRIED DIVORCED WIDOWED	SPOUSE'S NAME (IF APPLICABLE)

MAILING ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NUMBER: (CIRCLE PRIMARY) HOME CELL WORK	IS IT OK TO LEAVE MESSAGES? Y / N

EMAIL ADDRESS (OPTIONAL)

OCCUPATION	CURRENT EMPLOYER

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN

FAMILY CONTACT INFORMATION

LAST NAME	FIRST NAME	D.O.B (required for ID purposes)

PHONE NUMBER	MAY WE COMMUNICATE RESULTS? Y / N	MAY WE LEAVE A MESSAGE? Y / N

MAY THIS PERSON PICK UP/ DROP OFF HEARING DEVICE(S)? Y / N	RELATIONSHIP	EMERGENCY CONTACT? Y / N

EMERGENCY CONTACT NAME (If not listed above)	RELATIONSHIP	PHONE NUMBER

MEDICARE/INSURANCE INFORMATION

PRIMARY INSURANCE	POLICY HOLDER'S NAME/RELATIONSHIP	POLICY HOLDER'S DATE OF BIRTH/SSN

SECONDARY INSURANCE	POLICY HOLDERS'S NAME/RELATIONSHIP	POLICY HOLDER'S DATE OF BIRTH/SSN

HOW DID YOU HEAR ABOUT US? Check all that apply

- ☐ Ear Q ☐ Our website, Audgrp.com
- ☐ Friend/Family:_____
- ☐ Physician:_____
- ☐ Other: _____

HOW MAY WE COMMUNICATE WITH YOU?

- ☐ Email:_____ or ☐ same as above
- ☐ Letter
- ☐ Phone

May we leave a message? ☐ YES ☐ NO

ASSIGNMENT OF BENEFITS AND NOTICE OF PATIENT INFORMATION PRACTICES

I hereby assign all audiological benefits to include Medicare and Medicare Supplement to Audiology Group, LLC. . This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby agree to pay any and all charges that exceed or that are not covered by insurance. IN THE EVENT MY INSURANCE REQUIRES A REFFERAL, AND I DO NOT PROVIDE ONE AT THE TIME OF SERVICES, I AM RESPONSIBLE FOR ANY CHARGES INCURRED. I hereby authorize said assignee to release all information to secure the payment. To ensure continuity of care, I hereby authorize the release of all audiological records to Audiology Group, LLC and my primary and referring physicians. I also authorize Medicare and Medicare Supplement to furnish said assignee any information regarding payment of my claim. I acknowledge receipt of the Notice of Patient Information Practices. I ACKNOWLEDGE THAT I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES and I am in agreement with their use and disclosure of my protected health information for treatment, payment and operations of the practice. I understand that I may request, in writing, restrictions to the use or disclosure of my protected health records, and that I am able to provide access to my personal health information by written authorization.

Signature: _____ Date: _____