Coastal Audiology & Hearing Aid Center

Please present your insurance card at the time of check in

Payment is expected at the time of service.

Date	**PATIENT INFORMATION**		SSN	
Last Name	First Name			MI
Name you prefer to be called				
Birth Date	Gender M F	Spouse's Name		
Street				
City	State		County	Zip
Home Phone	Cell Phone	Work Phone		Leave message Y N
Email	Preferred contact: Home Cell Work Email			
Employer	Occupation			
Child's School	School District			
Primary Care Physician	Address			
I give consent to send a copy of my records to the Primary Care Physician listed above Y N				
Race/Ethnicity (optional): African American Asian or Pacific Islander American Indian Hispanic Caucasian				

EMERGENCY CONTACT		
Contact Name	Relationship	
Street		
City	State	Zip
Home Phone	Cell Phone	

PARENT / GUARDIAN (RESPONSIBLE PARTY IF UNDER 18)	
Name	Name
Birth Date	Birth Date
Street	Street
City/State/Zip	City/State/Zip
Phone	Phone
Relation to patient	Relation to patient
Employer	Employer

REFERRAL SOURCE

Self Paper Ad Radio Ad Friend / Family

Physician (name) _____ Other (list)

INSURANCE INFORMATION (WE MUST HAVE LEGIBLE COPIES OF ALL CARDS OR COMPLETE BELOW)	
Is the patient covered by insurance? Y N	
Primary Insurance Information	**Secondary Insurance Information**
Insurance	Insurance
ID#	ID#
Group#	Group#
Insured Name	Insured Name
Relation to patient	Relation to patient
Policyholder Birth Date	Policyholder Birth Date
Occupation	Occupation
FOR TRICARE: PLEASE PROVIDE THE SPONSOR'S SSN:	**SPONSOR'S NAME:**

Coastal Audiology & Hearing Aid Center

AUTHORIZATION AND RELEASE
By signing this consent form, I acknowledge that I have read, understand, voluntarily consent to, and authorize the following:
AUTHORIZATION OF TREATMENT
I authorize the administration and cost of all services for myself and my dependents.
GUARANTEE OF PAYMENT
I understand that I am financially responsible for the fees for all services rendered (and equipment and supplies provided to me). I guarantee payment of the portion of my account for which I am responsible within ninety (90) days of notification of the balance. I agree that, in the event I default and do not pay my balance, reasonable costs of collection [limited to no more than forty percent (40%) of the delinquent balance] and/or reasonable attorney fees may be added to the amount due on the account and I agree to be financially responsible for those additional charges. Patient Signature_____ Date_____
I authorize Coastal Audiology & Hearing Aid Center to release/obtain verbally, electronically and/or in writing confidential information obtained during the course of my examination and/or treatment to any person or entity including my insurance carrier, employer (if treatment is related to the employment), and/or other healthcare provider(s) for purposes of treatment, payment of charges, quality assurance and utilization review. I understand that should I choose not to release my records to a specific entity and/or person(s), I must specifically state so in writing. This assignment and authorization will remain in effect until revoked in writing by me. Patient Name Birth Date
Please also share my records with (name & address):
Patient/Guardian Signature Date