Mid America Audiology Group * 1417 Washington Ave, Suite 2 * Alton, IL 62002 * 618-462-7900

PATIENT INFORMATION

DATE:_____ HOME PHONE:_____ CELL: _____

NAME:_____ SOCIAL SECURITY #_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

GENDER: M / F AGE:_____ DOB:_____ SINGLE MARRIED WIDOWED SEPARATED DIVORCED

EMAIL:_____

PATIENT EMPLOYER:_____ PHONE:_____

PRIMARY CARE PHYSICIAN / REFERRING PHYSICIAN:_____PHONE:_____

EMERGENCY CONTACT:_____RELATIONSHIP_____PHONE:_____

PRIMARY INSURANCE:_____ SECONDARY INSURANCE:_____

ASSIGNMENT AND RELEASE

Please list names of family members with whom you would like us to share your medical records:

I agree to be financially responsible for this account and guarantee payment of all charges, whether or not paid by Insurance, including any rebilling fee that accrues on such charges. I assign directly to Mid America Audiology Group, Ltd, all insurance benefits, if any, otherwise payable to me for services rendered. I further understand and agree that if Mid America Audiology Group, Ltd. Places my account with an attorney or collection agency to obtain payment, I will be responsible for payment of any related fees, including attorney fees, court costs, process service fees, and any other reasonable expenses incurred by Mid America Audiology Group, Ltd.

I understand I am financially responsible for my Insurance Co-payment.

SIGNED:_____DATE:_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES, WRITTEN ACKNOWLEDGEMENT FORM, PATIENT CONSENT, AND AUTHORIZATION FOR THE RELEASE AND USE OF PROTECTED HEALTH INFORMATION.

I, _____ have been made available a copy of Mid America Audiology Group's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. I understand that this practice has reserved the right to change the privacy practices that are described in the Notice. In addition, I understand in the event that the policy is revised that a copy of the revised notice will be provided to me or made available at the next office visit.

I hereby give my consent to Mid America Audiology Group to use and /or disclose certain protected health information for the purpose of carrying out treatment, payment, or health care operations regarding all the information contained in the patient record of _____. (patient name)

I understand that I do not have to sign this authorization in order to receive treatment and have the right to refuse to sign this authorization. I have the right to revoke this authorization in writing at any time to the privacy official and written revocation of consent must be sent or delivered to our business office listed above. I will not be able to revoke this on consent in cases where Mid America Audiology Group has already relied on it to use to disclose my health information.

_____ _____ _____

Signature of Patient / Legal Guardian | Relationship to Patient | Date

YOU ARE RESPONSIBLE FOR YOUR CO-PAY AT THE TIME OF SERVICE

Mid America office staff has presented the patient with the Mid America Audiology Group's Notice of Privacy statement, but patient refused to sign it

_____ _____

Office Staff Signature | Date