Monica Walker
YOUR HEARING CARE EXPERT

PATIENT DEMOGRAPHICS & MEDICAL HISTORY

Comprehensive Intake, Medical History, and Contact Form

1. Patient Demographics

Full Legal Name: _____

Date of Birth: _____

Street Address: _____ **Apt #:** _____

City, State, Zip: _____ **Sex: [ ] M [ ] F [ ] Other**

Primary Phone: _____

Email Address: _____

2. Emergency Contact

Emergency Contact Name: _____

Relationship & Phone: _____

3. Medical History

Current Prescriptions & Over-the-Counter Medications (okay to provide copy of list):

_____

4. Verification Signature

Patient Signature: _____ **Date:** _____

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GENERAL CONSENT FOR EVALUATION & TREATMENT

Consent for Medical Diagnostics, Routine Care, and Clinical Operations

Terms of General Medical Consent

- **Consent for Diagnostic Evaluation & Routine Care:** I voluntarily consent to medical evaluations, diagnostic testing, routine clinical examinations, and general care performed by clinicians, and authorized staff members.
- **Right to Refuse Treatment:** I understand that I retain the right to discuss treatment options with my provider and may decline specific proposed evaluations or treatments at any time.

FINANCIAL RESPONSIBILITY & ASSIGNMENT OF BENEFITS

Financial Policy, Insurance Authorization, and Payment Agreement

Financial Agreements

• **Financial Responsibility:** I acknowledge full financial responsibility for all services rendered. I agree to pay all applicable amounts for services at the time of care.

• **Assignment of Benefits:** I hereby assign directly to the healthcare provider all medical benefits otherwise payable to me under my health insurance coverage for services rendered. I acknowledge that this practice is non-participating with Medicare and other subsidiaries.

• **Insurance Claims & Billing Authorization:** I authorize the practice to submit claims to my commercial insurance carrier on my behalf and release medical records strictly necessary for insurance billing and claims adjudication. **INSURANCE PROVIDER NAME:** _____.

Agreement & Signature

Guarantor / Patient Signature: _____ **Date:** _____

Printed Name: _____

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NOTICE OF PRIVACY PRACTICES

Acknowledgment of Receipt & Privacy Policy — HIPAA Compliance

Privacy Rights & Usage Summary

By signing below, you acknowledge that you have received, read, or were offered a copy of our Notice of Privacy Practices. This document details how your Protected Health Information (PHI) may be used and disclosed for Treatment, Payment, and Healthcare Operations (TPO), as well as your legal rights regarding your health records under the Health Insurance Portability and Accountability Act (HIPAA).

Patient Acknowledgment & Signature

Patient / Legal Guardian Signature: _____ **Date:** _____

Printed Name: _____ **Relationship to Patient:** _____

PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Family & Designated Representative HIPAA Release Form

1. Authorized Family Members / Representatives

I authorize this practice and its staff to discuss my Protected Health Information (PHI) and share relevant medical/billing records with the following designated family member(s), legal guardian(s), or trusted representative(s):

Person 1 Name: _____ **Relationship:** _____

Phone: _____

Person 2 Name: _____ **Relationship:** _____

Phone: _____

2. Terms & Right to Revoke

- Right to Revoke: I understand that I have the right to revoke or modify this authorization at any time by delivering a written revocation to the practice. Revocation will not affect any actions already taken in reliance on this authorization prior to receiving written notice.
- Voluntary Nature: Signing this form is voluntary. Treatment, payment, enrollment, or eligibility for benefits cannot be conditioned on signing this form.

3. Patient Acknowledgment & Signature

Signature: _____