Patient Registration

Name_____ Birth Date___/___/_____
First Middle Last

Address:					
Home Phone:		Work Phone:			
Mobile (Cell):		Email:			
I wish to be contacted in the following manner. (Select all that Apply)					
Leave message with call back number Only	Email	Home	Mobile	Text	Work
Okay to leave message with Detailed Information	Email	Home	Mobile	Text	Work
My Preferred Contact Method	Email	Home	Mobile	Text	Work
Emergency Contact					
Name:	Relationship:				
Mobile:	Home:		Work:		
My protected health information may be released to the following individuals:					
Name**:**	Relationship:				
Name**:**	Relationship:				

The HIPAA privacy rule gives an individual the right to request a restriction of uses and disclosures of their protected Health Information (PHI). I understand that I have the right to change the above information at any time by completing another form.

Primary Insurance	
Name of Insured:	Relationship:
Insured Birth Date:	Insured Employer:
Secondary Insurance	
Name of Insured:	Relationship:
Insured Birth Date:	Insured Employer:

Patient Agreement

_____ I authorize North Alabama Audiology to release any information acquired in the course of my treatment to process my medical claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

_____ I acknowledge that I have reviewed or received a copy of the Notice of Privacy Practices for North Alabama Audiology.

_____ I understand certain procedures performed by North Alabama Audiology may not be covered by my individual insurance contract. I accept full financial responsibility for the immediate payment of any charges not covered by my insurance contract. If my insurance contract requires a specific referral or authorization, I acknowledge and agree that any services rendered will be considered a self-referral for which I (or my responsible party) shall be solely liable for payment. Should I fail to pay for any of the services rendered, I agree to pay all reasonable costs associated with collection; including, but not limited to attorney's fees. I have read this financial responsibility policy and agree to pay for all services not covered by my individual insurance contract.

_____ _____
(Patient Signature) (Date)

_____ _____
(Responsible Party Signature) (Date)