Audiology ASSOCIATES

PATIENT INTAKE

Today's date: _____

Patient's Last name:_____First:_____Middle____ ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

Marital status: ☐ Single ☐ Married ☐ Widowed Name of Spouse (if applicable)_____

Date of Birth:_____Gender: M☐ F☐ Primary Care Doctor:_____

Email Address: _____ Ears, Nose, Throat(ENT):_____

Street address: _____

P.O. Box:_____City:_____State:_____ZIP_____

Home phone:_____Cell phone: _____ Other contact: _____

Occupation:_____Employer:_____Employer phone: _____

REFERRED BY: *(please check one)*: ☐ Doctor:_____ ☐ Insurance

☐ Friend/Family_____ ☐ Website ☐ Mailer ☐ Newspaper

☐ Internet search ☐ Other? Explain:_____

	Primary Insurance	Secondary Insurance
Insurance name		
Subscriber's name		
ID number		
Subscriber's DOB		

FINANCIAL RESPONSIBILITY

I authorize Audiology Associates of Lancaster, LLC.(AAOL) to release any medical or other information necessary to process this claim. I also authorize payment of medical benefits to be made directly to AAOL. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance. If my insurance company has not paid their portion within 90 days of being properly billed, I understand that the balance will become due and payable from me.

Payment for all hearing aids are due within 90 days of delivery. If not paid within 90 days, a service charge will be added to your account. All batteries, repairs (major or minor), earmolds, home visits and A.L.D.s are due at the time of service. If not paid within 30 days, a service charge will be added to your account. Hearing evaluations are not included in the cost of hearing aids.

In case of default I promise to pay any legal interest on the balance due, along with any collection agency costs and reasonable attorney fees incurred to effect collection on this account.

Patient/Guardian Signature:_____Date: