Hear Virginia

Patient Information Form

Date_____

Patient Name_____DOB_____

Primary phone_____ Alt. #_____

Email _____

Mailing Address_____

_____

Emergency Contact_____Phone_____

Relation to Patient_____ Please check: Employed Full Time ____ Part time ____ Retired ____

Primary Care Physician(PCP)_____

PCP Office Location_____

How did you hear about us? _____

Reason for your appointment _____

_____

Insurance Information

If applicable, please present your insurance information to our front office staff.

Please Read Carefully and Sign Below

- I agree to allow Hear Virginia to release information contained in my record to my healthcare providers as it relates to my hearing healthcare needs.
- I give permission to Hear Virginia to release information contained in my record to my insurance company, if applicable.
- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the costs of professional services rendered by, and products sold by, Hear Virginia.
- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability (HIPAA) policy of this office. (Copies are available at our front desk.)
- I certify that this information is true and correct to the best of my knowledge, and I hereby give Hear Virginia permission to treat my hearing healthcare needs.

I have read and understand all the above information

Patient Signature **Date**