LakeShore Audiology

Phone: (716) 674-4188 Fax: (716) 674-4834

PATIENT DEMOGRAPHICS

Patient Name :_____
Last First M.I

Preferred Name (Nickname): _____ DOB: ____/____/____ Gender: M ☐ F ☐

Address: _____
Street Address City State Zip

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Email*: _____

*Email will not be shared and will only be used for occasional newsletters and office announcements.

Retired? : Yes ☐ No ☐ Occupation: _____
(If retired, former occupation)

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Spouse/Partner's Name: _____

Emergency Contact: _____ Phone# _____

Relation to Patient: _____

INSURANCE INFORMATION

Please give your insurance card to our front office staff so we can make a copy for our records.

Primary Insurance Co.: _____ Secondary Insurance Co.: _____

*If the insurance is **NOT** under your name:*

Name of Subscriber: _____

DOB: ____/____/____ Relationship: _____

Primary Care Physician: _____

Referring Physician: _____

How did you hear about us? _____

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PATIENT INFORMATION

Name: _____ DOB: ____/____/____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

PRIVACY POLICY

The undersigned hereby permits Lake Shore Audiology and its employees to discuss the patient's Personal Health Information (PHI) for purposes of treatment to obtain payment for the patient's treatment and in the other circumstances listed in the practice's Privacy Policy. The undersigned also grants permission to release PHI to other healthcare providers involved in the patients care.

Please list the names, relationship and phone number of any individual(s) that you authorize our office to release your medical information to on your behalf.

Contact Name	Relationship	Phone Number

1. _____

2. _____

CONSENT TO TREATMENT, ASSIGNMENT & FINANCIAL AGREEMENT:

Assignment, Release & Financial Agreement: I authorize treatment of person named above by Lake Shore Audiology, PC and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to Lake Shore Audiology, PC and I am financially responsible for non-covered services. I further agree the account is to be paid in full at the time of service unless other arrangements have been made. Should the account be referred to a collection agency or an attorney for collection, I will pay all reasonable collection agency or attorney fees and court costs. I also authorize the release of medical information to my insurance company, Medicare or any third party payer to facilitate health care, processing of claims, and audit of payments.

Patient or Guardian Signature: _____ Date: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

By signing this document, I hereby acknowledge that I have received, or was offered and declined to take, a copy of the Notice of Privacy Practices of Lake Shore Audiology. (Copies are available at the front desk.)

Patient or Guardian Signature: _____ Date: _____

Print name and relationship if signed on behalf of patient: _____