



**Pt. intake-
HAF(Blank)**

Hearing Associates of Florence
 1901 Hwy. 101, Suite A
 Florence, Oregon 97439
 Phone: 541-997-7617
 Fax: 541-997-3962
 www.hearingassociatesofflorence.com

Patient Name:		Sex:
Address:		
City/State/Zip:		
Primary Phone #:		Secondary Phone #:
Birth Date:	Age:	Primary Care Dr.:
Email:		
Emergency contact:		Relationship:
Emergency contact phone number:		

Primary Insurance:	
Person responsible for insurance:	
Relationship to Patient:	Birthdate:
Address(if different from patient's):	
Person Responsible Employed by:	Occupation:

Secondary Insurance:	
Person responsible for insurance:	
Relationship to Patient:	Birthdate:
Address(if different from patient's):	
Person Responsible Employed by:	Occupation:

May we leave a message on your answering machine? Yes No

May we leave a message with anyone who answers the phone numbers provided? Yes No

May we contact you via e-mail? Yes No

May we contact you via text? Yes No

Reason for appointment:

How did you hear about us?

Referred by Friend/Family _____

Referred by Physician _____

Yellow Pages Insurance Mail Employer Newspaper Radio Website

Other _____

Privacy Policy (Please read carefully and sign below)

- I give permission to Hearing Associates of Florence, to release information, verbal and written(contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, employer, related health care providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.

- I authorize Hearing Associates of Florence to use and release my protected health information, i.e., my contact information, for marketing related to hearing care products or services offered by Hearing Associates of Florence. Hearing Associates of Florence does not sell your protected health information to third parties.

- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.

- I have read and verified all of the information on this sheet, and certify this information is true and correct to the best of my knowledge, and I hereby give my hearing care provider permission to treat my concerns.

Patient Signature (A copy of this signature is as valid as the original) Date

Signature of Parent or Guardian Date