First Coast Hearing Clinic

904-824-6007-St. Augustine

386-447-7364 Palm Coast

Last Updated: 3/14/17

Privacy Agreement:

Patient Information

(if this is an update, please cross out and correct any information that has changed) ****Required fields.***

Patient's Name* _____
First Initial Last

Responsible Party (if patient is a child, Parent or Guardian) _____

Address* _____

Home Phone _____ **Work** _____ **Mobile** _____ **Other** _____

Date of Birth* _____ **Sex*** M F **Email*** _____

Marital Status* Married Single Other _____ **Employment Status*** FullTime PartTime None

Referring Physician* _____ **Emergency Contact** _____
Name & Phone Number

How did you hear about us?* _____

Primary Insurance Information

(If different than patient)

Insured's Name* _____
First Initial Last

Address* _____

City* _____ **State** _____ **Zip Code** _____

Home Phone _____ **Insured Date of Birth*** _____ **Insured Sex** M F
(circle)

Patient Relation to Insured* Self Spouse Child Other **Group#** _____

Insurance Co. Name* _____ **Subscriber ID#*** _____

Insurance and Financial Responsibility Information

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

Please read carefully and sign below.

- I give permission to First Coast Hearing Clinic (FCHC) to release information, verbal and written (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, employer related healthcare providers, assignees, and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.
- I authorize FCHC to use and release my protected health information, ie., my contact information, for marketing related to hearing care products or services.
- I understand that the practice may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described. I understand that this marketing authorization is in effect until a revocation is received by the practice.
- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPPA) 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 all of the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge and hereby give FCHC permission to treat my concerns.

Signature _____ **Date** _____