Audiology Group
of Northern Colorado

REGISTRATION INFORMATION

PATIENT'S LAST NAME	FIRST NAME	MIDDLE	SOCIAL SECURITY #

DATE OF BIRTH	SEX (CIRCLE ONE)	MARITAL STATUS (CIRCLE ONE)	SPOUSE'S NAME (IF APPLICABLE)
	M/F	SINGLE MARRIED DIVORCED WIDOWED	

MAILING ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NUMBER: (CIRCLE PRIMARY)	HOME	CELL	WORK	IS IT OK TO LEAVE MESSAGES?
				Y / N

EMAIL ADDRESS To opt out of receiving practice updates/newsletters, check here ☐

OCCUPATION	CURRENT EMPLOYER

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN

FAMILY CONTACT and DESIGNATED INDIVIDUAL INFORMATION

I HEREBY AUTHORIZE ONE OR ALL OF THE DESIGNATED PARTIES BELOW TO REQUEST AND RECEIVE THE RELEASE OF ANY PROTECTED HEALTH INFORMATION REGARDING MY TREATMENT, PAYMENT OR ADMINISTRATIVE OPERATIONS RELATED TO TREATMENT, OR ANY PAYMENT. I UNDERSTAND THAT IDENTITY OF THE DESIGNATED PARTY/PARTIES MUST BE VERIFIED BEFORE THE RELEASE OF ANY INFORMATION.

LAST NAME	FIRST NAME	RELATIONSHIP
PHONE NUMBER	CHOOSE ONE OR BOTH EMERGENCY CONTACT / DESIGNATED IND.	MAY WE LEAVE A MESSAGE? YES / NO
LAST NAME	FIRST NAME	RELATIONSHIP
PHONE NUMBER	CHOOSE ONE OR BOTH EMERGENCY CONTACT / DESIGNATED IND.	MAY WE LEAVE A MESSAGE? YES/ NO

INSURANCE INFORMATION

INSURANCE SUBSCRIBER IF NOT PATIENT	POLICY HOLDER'S NAME/RELATIONSHIP	POLICY HOLDER'S DATE OF BIRTH

HOW DID YOU HEAR ABOUT US? Check all that apply

☐ Ear Q ☐ Our website, Audgrp.com
☐ Friend/Family:_____
☐ Physician:_____
☐ Other: _____

HOW MAY WE COMMUNICATE WITH YOU?

☐ Email:_____ or ☐ same as above
☐ Letter
☐ Phone

May we leave a message? ☐ YES ☐ NO

ASSIGNMENT OF BENEFITS AND NOTICE OF PATIENT INFORMATION PRACTICES

I hereby assign all audiological benefits to include Medicare and Medicare Supplement to Audiology Group, LLC. . This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original, I hereby agree to pay any and all charges that exceed or that are not covered by insurance. IN THE EVENT MY INSURANCE REQUIRES A REFFERAL, AND I DO NOT PROVIDE ONE AT THE TIME OF SERVICES, I AM RESPONSIBLE FOR ANY CHARGES INCURRED. I hereby authorize said assignee to release all information to secure the payment. To ensure continuity of care, I hereby authorize the release of all audiological records to Audiology Group, LLC and my primary and referring physicians. I also authorize Medicare and Medicare Supplement to furnish said assignee any information regarding payment of my claim. I acknowledge receipt of the Notice of Patient Information Practices. I ACKNOWLEDGE THAT I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES and I am in agreement with their use and disclosure of my protected health information for treatment, payment and operations of the practice. I understand that I may request, in writing, restrictions to the use or disclosure of my protected health records, and that I am able to provide access to my personal health information by written authorization.

Signature: _____ Date: _____