CONSTANCE BROWN HEARING CENTERS

Please present your insurance card(s) at the time of check-in.

Payment is expected at the time of service.

Date	**PATIENT INFORMATION**		CBHC#	
Last Name		First Name		MI
Preferred Nickname		Preferred Pronouns: she/her/hers he/him/his they/them/their zie/hir/hirs		
Date of Birth	Legal Gender: M F	Spouse's Name		
Address				
City		State	County	Zip
Home Phone	Cell Phone	Work Phone		Leave message: Y N
Email		Preferred contact: Home Cell Work Email		
Employer		Occupation		
Child's School		School District		
Primary Care Physician		Address		
Race/Ethnicity: American Indian Asian Black or African American Hispanic or Latino Mixed MENA (Middle Eastern or North African) Pacific Islander White Other				
EMERGENCY CONTACT				
Contact Name		Relationship		
Address				
City		State		Zip
Home Phone		Cell Phone		
PARENT / GUARDIAN (RESPONSIBLE PARTY IF UNDER 18)				
Name		Name		
Date of Birth		Date of Birth		
Address		Address		
City/State/Zip		City/State/Zip		
Phone		Phone		
Relation to Patient		Relation to Patient		
Employer		Employer		
HOW DID YOU HEAR ABOUT US				
Self Magazine Radio Google Facebook Healthy Hearing Phonebook Health Fair				
Physician (name) _____ Friend / Family _____				
Other (list):				
INSURANCE INFORMATION (Complete unless we have a copy of your card)				
Is the patient covered by insurance? Yes No				
Primary Insurance		Secondary Insurance		
Policyholder Name		Policyholder Name		
Policyholder Date of Birth		Policyholder Date of Birth		
Relation to Patient		Relation to Patient		
ID#		ID#		
Group#		Group#		

PLEASE READ AND COMPLETE REVERSE SIDE - SIGNATURES REQUIRED

CONSTANCE BROWN HEARING CENTERS

Date	Patient Name	CBHC#

RELEASE / OBTAIN RECORDS / INFORMATION

I authorize Constance Brown Hearing Centers to release/obtain verbally, electronically and/or in writing confidential information obtained during the course of my examination and/or treatment to any person or entity including my insurance carrier, employer (if treatment is related to the employment), and/or other healthcare provider(s) for purposes of treatment, payment of charges, quality assurance and utilization review. I understand that should I choose not to release my records to a specific entity and/or person(s), I must specifically state so in writing. This assignment and authorization will remain in effect until revoked in writing by me.

Patient Name _____ Date of Birth _____

Please also share records with (name & address):

Physician

Spouse

Family Member

School

Other

Signature X_____ **Date** _____

Parent/Guardian Signature if Minor X_____ **Date** _____

RECEIPT OF PRIVACY PRACTICES

By signing this consent form, I acknowledge that a copy of the Notice of Privacy Practices of Constance Brown Hearing Centers is available to me upon request.

Signature X_____ **Date** _____

Parent/Guardian Signature if Minor X_____ **Date** _____

FINANCIAL ASSISTANCE

Constance Brown Hearing Centers will help find financial assistance or adjust fees for those in need.

Do you wish to be considered for this assistance? _____ Yes _____ No

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barrier prohibited obtaining the acknowledgement

_____ Other (please specify)