Nilsson Audiology & HEARING AID CLINIC

Nilsson Audiology LLC

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Date:	**: JKN**

Personal Information

Last Name	First	MI	Age	Birth Date

Street	Email
City State Zip	Last Four of Social Security
Primary Phone	Alternative Phone
Loved One	Loved One"s Phone
Family Physician	Occupation
Physician Street	Patient Preferred Name
Physician City State Zip NPI	Preferred Form of Contact
Referral Source	Referral Detail

Insurance Information

Primary Insurance	Primary ID#
Secondary Insurance	Secondary ID#

Receipt of Notice of Privacy Practice - Written Acknowledgment Form

I, , have been offered/received a copy of Nilsson Audiology and Hearing Aid Clinic, LLC Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

_____ _____

Signature of Patient Date

Nilsson Audiology and Hearing Aid Clinic, LLC may participate with my insurance however, Nilsson Audilogy and Hearing Aid Clinic, LLC does not participate with **MEDICAID**. I understand that all deductibles, copays and services not covered by my insurance company, are my responsibility. If I fail to obtain a valid and current referral and/or script, I am responsible for payment of any charges. Nilsson Audiology and Hearing Aid Clinic, LLC will file insurance claims on my behalf. I also understand that as a part of my treatment, payment or healthcare services, it may become necessary to disclose my health information to another entity and I consent to such disclosure for these permitted uses, including via fax. I authorize payment of medical benefits to the undersigned supplier for services.

_____ _____

Signature of Patient Date

[ ] Patient refused to sign/read. _____Initials _____/_____/_____ Date