Physician's Choice Hearing & Dizziness Center, INC.

Patients Full Name_____ **Date of Birth**_____/_____/_____

Street_____City_____State_____Zip_____

Home Phone # ( )_____Work ( )_____**Cell ( )**_____

Spouse_____Date of birth_____/_____/_____

E-Mail Address:_____

Primary Insurance:_____**Secondary:**_____

Occupation:_____**Place of Employment:**_____

Is this Accident related? *YES_____ No _____, If yes, date of accident:* _____

Referred By_____ **Primary Physician's Name**_____

Emergency Contact_____Phone( )_____Relationship:_____

Patient Authorizations and Acknowledgement:

(A) I authorize the release of any medical or other information necessary to process my insurance claim.

(B) I authorize the release of any medical or other information requested to referring party, any Physicians I have seen, Workers' Compensation carriers, Vocational Rehabilitation, and Attorneys involved in my case.

(C) I authorize payment of government, medical, and insurance benefits to Physician's Choice Hearing & Dizziness Center, Jeff Clark, AuD and Scott Sims, AuD.

(D) I acknowledge that I have read and received a copy of Physician's Choice Hearing & Dizziness Center, Inc.'s Notice of Privacy Practices.

*By signing below I certify that ALL above information is true and accurate. **I also agree to above Authorizations (A), (B), and (C) and Acknowledgement (D).**

Signature of Patient or Parent, or Legal Guardian **Date**

PAYMENT FOR SERVICES IS MY RESPONSIBILITY

_____ By initialing this section and signing below, I acknowledge that payment for services rendered is my responsibility, that submission of insurance claims is a courtesy, that I am obligated to provide Physician's Choice Hearing & Dizziness Center with my insurance information prior to my visit, and that it is my responsibility to pay in full all insurance plans deductables, copays, and coinsurance, at the time I am seen.

Signature of Patient or Parent, or Legal Guardian **Date**