Date ________________

Patient Name ____ DOB ______________
First MI Last mm dd yyyy

Mailing Address ____

Home Phone # ______________ Cell Phone # ________________ Alt/Work Phone # ________________

Email ____________________________ SSN ________________________ Gender ______________

Employment Status Part Time Full Time Retired Self Employed Not Employed Disabled

Occupation ________________________ Employer ____________ Primary Physician ______________

Marital Status Married Single Widowed Divorced Long-term commitment

Spouse Name ____ DOB ______________
First MI Last mm dd yyyy

Spouse's SSN ___________________________ Spouse's Employer/Occupation ______________________

How did you hear about us? ____

Primary reason for today's visit ____

If patient is under the age of 18, responsible party must complete remainder of this section.

Name of Responsible Party _______________________________________ DOB ______________
First MI Last mm dd yyyy

Relationship to Patient ________________________________ Responsible Party SSN ________________

Contact # ____

Please read carefully and sign below.

- I acknowledge that I have reviewed, or I have been provided, the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where, and why my confidential health information may be used or shared. I acknowledge that HCP may use and share my confidential health information with others in order to treat me and in order to arrange for payment of my bill.
- I hereby authorize the following individual(s) to receive information regarding my medical condition(s) and related billing information:

  ____

- This is a training facility and I acknowledge that video recording devices are in use.
- 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. If this account is assigned to an attorney/agency for collection and/or suit, I, as the responsible party, agree to pay all cost of collection, including attorney fees, collection fees, and contingent fees to the collection agency of not less than 40% of the total collection amount. Such contingency fees will be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency.
- I have read all 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 Hearing Care Partners permission to treat my concerns.

Patient / Legal Guardian Signature ______________________________________ Date ______________