Hearing care professionals since 2005

vancouver hearing AID CENTER

Patient Intake Form

Today's Date _____

CLIENT INFORMATION

Legal Name _____ Birthdate _____

Primary Address _____

City _____ State _____ Zip _____

Phone Number: Home_____ Cell_____ Work _____

E-mail Address _____ Occupation _____

☐ Male ☐ Female ☐ Other _____ Spouse/Partner/Companion Name:_____

EMERGENCY CONTACTS / PERSONAL REPRESENTATIVE

person 1 info

Name _____ Relationship to Patient _____

Address _____

Phone _____ E-mail _____

Responsible for: Financial Decisions? ☐ Y ☐ N Medical Decisions? ☐ Y ☐ N

person 2 info

Name _____ Relationship to Patient _____

Address _____

Phone _____ E-mail _____

Responsible for: Financial Decisions? ☐ Y ☐ N Medical Decisions? ☐ Y ☐ N

How did you hear about us? _____

PRIMARY PHYSICIAN

Name _____ City _____Phone_____

INSURANCE

Vancouver Hearing Aid Center is pleased to participate with many insurance plans and networks. Patients should contact their insurance companies directly to check for network participation and benefit information.

Primary Insurance _____ ID# _____Group#_____

Plan or Program Name _____ Phone _____

Turn over for Consent Form

Consent to Use and Disclosure of Health Information

(For HIPAA Compliance Purposes)

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PRIVACY NOTICE

Vancouver Hearing Aid Center values you as a patient and respects the privacy of your personal and medical information that is disclosed to us the course of our treatment relationship with you.

I understand that I am granting Vancouver Hearing Aid Center (the "Provider") to use and disclose my protected health information for the purposes of treatment, payment, and health care operations. This may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, test results, treatments, procedures and similar types of health-related information.

I understand that The Notice of Privacy Practices provides more detailed information about how the provider may use and disclose my protected health information. I have been informed that I can request a copy of "the Notice" at any time by hard copy or email. The "Notice" is subject to change and will be updated accordingly.

HEALTH CARE MARKETING COMMUNICATIONS AUTHORIZATION:

I understand provider does not sell or release patient information to third parties. The provider gives me the opportunity to receive promotions or information about their products and services. This is a normal part of our provider-patient relationship, and no permission is required for us to do so. At Vancouver Hearing Aid Center, we believe such communication is a valuable part of our relationship with you.

CONSENT FOR SERVICES AND TREATMENT

I hereby agree to and give consent to any diagnostic testing, rehabilitation or treatment rendered to myself as a patient of Vancouver Hearing Aid Center and the provider assigned to care for me.

Per the State of Washington, Individuals are entitled to a copy of the audiogram used to conduct hearing evaluations and any test results.

YOUR SIGNATURES

Hearing to use and disclose my protected health information as set forth above. I also consent to services and treatment as described above:

Print Name: _____

Signature_____ Date: _____

If you are the personal representative but not the patient, then please fill out below:

Print Your Name: _____

Relationship to Patient_____ Patient Name_____

Your Signature_____ Date: _____