

We like to know how our patients find us. Please check the most influential sources of information.

Referred by

about this practice:

Employer _____ Promotional Call _____ Newspaper Ad _____ Mail _____ Radio _____

Health/Senior Fair _____ Insurance _____ Online/Social media _____ Sponsored Event _____

Referred by a friend: _____

Referred by physician: _____

Reason for Appointment _____

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Please give your insurance information to our front office

Insurance

staff so we can make a copy for our records.

Patients Employer _____ Occupation _____

Patient Address _____

Primary Insurance _____ ID Number _____

Subscribers Name _____ DOB _____ Phone [if different] _____

Relationship to patient Self Spouse Child Other

Subscriber Employer _____

Employer Address: _____

Please read carefully and sign below:

- I give permission to Tobias Hearing Inc, to release information, verbal and written [contained in my medical record and other related information], to my insurance company, rehab nurse, case manager, attorney, employer, related health care providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers maybe used for quality purposes.
- I authorize payment of medical benefits to be made directly to Tobias Hearing Aids, Inc for services rendered. I understand and agree that, regardless of my insurance status, I agree to pay, in a current manner, any balance of charges over and above insurance payment. I understand and agree that, regardless of my insurance, status, I am ultimately responsible for the balance on my account for professional services or purchases rendered.
- I authorize Tobias Hearing Inc, to contact me for all purposes related to my visit, including marketing-related correspondence, via email, voicemail, and text. I further understand that I can revoke my authorization to receive correspondence via email, voicemail and text by providing written notification to my practice.

- I authorize Tobias Hearing, Inc, to use and release my protected health information, i.e., my contact information for marketing related to hearing care products or services.
- I understand that my practice may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party who product or service is being described. I understand that this marketing authorization is in effect until a revocation is received by this practice.
- I acknowledge that I have received and reviewed the Health Insurance Portability and Accountability Act [HIPAA] policy of this office.
- 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 I hereby give my hearing care provider permission to treat my concerns.

I have read and understand all the above information

Patient Signature [A copy of this signature is as valid as the original] Date

Signature of Parent or Guardian Date