Bay Area Audiology
State-of-the Art Hearing Diagnosis & Solutions

NEW PATIENT INFORMATION

Name:_____ Male □ Female □

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email:_____

Date of Birth:_____ Single □ Married □ Other □

Employed □ Full-Time Student □ Part-Time Student □ Retired □

Employer/School_____

Emergency Contact: _____ Contact Phone:_____

Power of Attorney (POA): _____ Contact Phone:_____

How did you hear about us:_____

Primary Care Doctor:_____ Phone or Location:_____

Referring Doctor: _____ Contact Phone:_____

INSURANCE INFORMATION

Insurance Policy Holder (if not patient):_____ Relation to Patient:_____

Date of Birth:_____ Home Phone (if different):_____

Address (if different):_____

City:_____ State:_____ ZIP:_____

Primary Insurance Company:_____

Secondary Insurance:_____

424 Barnes St., Suite 102 • Bel Air, MD 21014 • p (410) 838-4327 • f (410) 510-1814
www.belairhearingaids.com

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

1. I authorize Bay Area Audiology, LLC to release PHI about me to the family members or other individuals listed below, this information may be oral or written. I authorize my PHI to be disclosed only to the following identified individuals *(there is no limit to the number of individuals that may be authorized to receive my PHI):*

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

2. I also request that the following limitations be placed on the disclosure of my PHI to my family members or other identified above (fill out only if you wish to limit some disclosures of PHI to the individuals listed above):

_____

_____

PLEASE SHOW ALL INSURANCE CARDS TO RECEPTIONIST

- I certify that the information provided above is correct.
- I consent to the usage of a copy of this authorization in place of the original.
- I hereby authorize insurance submissions and direct payment of any medical benefit for services provided to be sent directly to Bay Area Audiology, LLC. I further authorize the release of information to primary/secondary insurance companies.
- I understand that I am ultimately responsible for the balance on my account for services rendered, and it is my responsibility to know the rules and regulations of my health insurance, as well as what coverage is included with my specific plan.
- I understand that this information will not be sold or given to any third party in exchange for monetary compensation. By signing below, I consent to receiving marketing updates (via direct mail, email, or phone) including but not limited to: clinic service notifications, health notifications, marketing or promotional events (such as educational seminars, free battery giveaways, etc.), and any other service or product updates could benefit me or help to improve my health. In some instances, the cost of a mailing or other communication may be paid for by a hearing aid company. I understand that I can revoke this authorization at any time.
- I understand that once PHI is disclosed to the individuals listed above in the Authorization for Release of PHI, federal privacy protections may no longer apply to those disclosures and the Practice has no control over the use or re-disclosure of the information by my family members or other individuals who received my PHI.
- I acknowledge that I received a copy of Bay Area Audiology's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area and that any revised Notice of Privacy Practices will be made available.

Signature:_____ Date:_____

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