Sandra Leahy, Au.D.
Kathleen Sawhill, Au.D.

hearingsolutions of northwest michigan

Name Date _____

Dr./Mr./Mrs./Ms./Miss:_____
First MI Last

Date of Birth _____

Address _____
Street City State Zip

Home Telephone _____ Work Phone _____

Cell Phone _____ Email _____

Appointment Reminders: Please send me reminders for my appointments via

☐ SMS Text Message to Cell Phone Number: _____

☐ Email to Email Address: _____

In case of Emergency, please contact:

Name _____ Telephone (home) _____

Relationship _____ Telephone (Mobile) _____

Primary Care Physician _____

How did you hear about us? _____

Primary Health Insurance: _____

Insurance ID Number: _____

Secondary Health Insurance: _____

Secondary ID Number: _____

In order for us to file an insurance claim for you, the following must be completed

I authorize Hearing Solutions of Northwest Michigan, LLC to release any medical and/or other information necessary to process my claim.

I authorize release of hearing test results to any medical provider involved in the management of my health care.

I authorize payment of medical benefits be made directly to Hearing Solutions of Northwest Michigan, LLC for services provided. This authorization shall remain in effect until otherwise stated, in writing, by myself.

I agree to accept financial responsibility for any services covered or not covered by my insurance provider, including co-pays, co-insurance, and deductibles.

I acknowledge that I have been offered a copy of the Notice of Privacy Practices.

_____ ____/____/____

Signature of Patient/Parent/Guardian Date

hearingsolutions of northwest michigan

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I received a copy of Hearing Solutions of Northwest Michigan's Notice of Privacy Practices and Financial policy. 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, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

_____

Printed name of patient or personal representative Date

_____

Signature of patient or personal representative Date