PATIENT INTAKE DEMOGRAPHICS

Patient Full Name: _____ **Date of Birth**: _____

Address: _____

City, State, Zip_____

Contact: _____
Home **Cell** **Email**

Sex: Male _____Female _____Non-Binary _____ **Marital Status**: _____

Race: _____ **Ethnicity:** Hispanic or Non-Hispanic **Primary Language**: _____

Social Security Number: _____

Employment Status: _____ **Employer's Name**: _____

Emergency Contact Name: _____ Phone:_____

Reason for today's visit: _____

_____

Referred By: _____

How did you hear about Wave Audiology: _____

Primary Care Physician Name: _____

Wave Audiology
543 NW Lake Whitney Place, Suite 103
Port St. Lucie, FL 34986
P: 772.362.3964
F: 772.251.0425
www.waveaudiology.com

Medical History

Patient Name: _____ **Date of Birth**: _____

Have you had any of the following conditions (Check all that apply):

☐ Kidney Disease	☐ Diabetes	☐ Hearing Loss
☐ Hypertension	☐ Visual Problems	☐ Hearing Aids
☐ Sinus Issues	☐ Cardiac Conditions	☐ Tinnitus
☐ Cancer_____	☐ Head Trauma	☐ Noise Exposure
☐ Migraines	☐ Surgery on Ears	☐ Family History- Hearing Loss
☐ Current Smoker (Tobacco or Vaping)	☐ Alcohol Consumption _____ Drinks / Week	☐ Lightheadedness
		☐ Vertigo
		☐ Imbalance / Unsteadiness

List all current medications: _____

_____

_____

_____

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Assignment of Benefits

To facilitate the processing of insurance claims for you and payment agreement:

1. I hereby assign to you, my health care provider, all medical and hearing aid benefits to which I am intitled, including Medicare, private insurance, and any other health insurance.
2. I hereby authorize said assignee to release all information to secure payment.
3. I understand that I am financially responsible for all charges, whether or not paid by said insurance, and the payments are due at the time services are rendered.
4. I understand and agree that, in the event that I fail to make payment for services rendered to me, my name and account may be turned over to an attorney or collection agency, and I agree to pay said collection agency's fees for collection, court costs, and/or reasonable attorney's fees that may be incurred in the collection of any outstanding balances.

I hereby agree to the release of all medical information held by Dr. Lindsay E. Gracey and/or Wave Audiology to any referring physician whom I have seen or will be seeing, to any insurance company to facilitate payment and to myself, upon my request, or to anyone else whom I may designate in writing.

If Dr. Lindsay E. Gracey or Wave Audiology are not participating providers in my insurance carrier, I understand that I am fully responsible for any and all balances due for services rendered, and I agree to pay any balance as services are rendered.

I CERTIFY THAT I HAVE READ ALL OF THE ABOVE, FULLY UNDERSTAND, AND AGREE TO SAME:

_____ _____

Patient Name (Printed) Signature of Insured/Parent/Guardian

_____

Date

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Authorization to Share Protected Health Information

Patient Name: _____ **Date of Birth**: _____

I authorize Wave Audiology and Dr. Lindsay E. Gracey to share protected health information with the following persons:

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

This includes:

- ☐ All Audiologic Information
- ☐ Test Results
- ☐ Telephone Consults
- ☐ Billing Information
- ☐ Insurance Information
- ☐ Appointment Information

This authorization will be in effect until authorization is revoked.

_____
Signature of Insured/Parent/Guardian

_____
Date

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Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Wave Audiology for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to the conduct health care operations of Wave Audiology. I understand that diagnosis or treatment of me by Wave Audiology may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Wave Audiology *Notice of Privacy Practices* prior to signing this document. The *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Wave Audiology. The *Notice of Privacy Practices* for Wave Audiology is also provided at 543 NW Lake Whitney Pl, Suite 103 Port Saint Lucie, FL 34986. This *Notice of Privacy Practices* also describes my rights and the duties of Wave Audiology with respect to my protected health information. Wave Audiology reserves the right to change the privacy practices that are described in the *Notice of Privacy Practices*

Lifetime Authorization: By signing below I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent or this physician or supplier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or to the party who accepts assignment. The original authorization will be kept on file by Wave Audiology.

I may obtain a revised *Notice of Privacy Practices* by requesting in writing from Wave Audiology or asking for one at the time of my next appointment.

I CERTIFY THAT I HAVE READ ALL OF THE ABOVE, FULLY UNDERSTAND, AND AGREE TO SAME:

_____ _____

Patient Name (Printed) Signature of Insured/Parent/Guardian

_____

Date

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