Rocky Mountain Audiology

56 Edwards Village Blvd. Suite 222, Edwards, CO 81632 970.926.6660

Referred by:_____DATE:_____

PERSONAL INFORMATION:

PATIENT'S NAME_____
FIRST MIDDLE LAST

MAILING ADDRESS:_____
CITY STATE ZIP

TELEPHONE (HOME) _____ (WORK)_____

CELL:_____ EMPLOYMENT STATUS:_____

EMERGENCY CONTACT:_____PHONE:_____

BIRTHDATE:_____ AGE:_____ MALE☐ FEMALE☐ MARITAL STATUS _____

SSN:_____ IF PATIENT IS A MINOR MOTHER/FATHER NAME:_____

FULL NAME PRIMARY CARE PHYSICIAN _____

EMAIL ADDRESS: _____ May we contact you via email? YES☐ NO☐

INSURANCE INFORMATION - PLEASE READ AND SIGN/INITIAL:

DISCLAIMER: As a professional courtesy, we will submit your claim to your insurance provider, but this does not guarantee their payment. You accept responsibility for co-pay, deductibles, or uncovered procedures. Any unpaid balance will accrue a rebilling fee of$10.00 per billing cycle. If your account becomes delinquent, it may be forwarded to an outside agency without notice. Any collection fees, attorney fees, court costs or returned check fees are the responsibility of the adult person named on this account. PLEASE INITIAL: _____

If health insurance is not in your name, please provide the following information:

_____ _____
Name of insured Relationship to patient

_____ _____
Insured's Date of Birth Insured's Employer

I hereby authorize RMA to furnish information to my insurance carrier concerning my illness and treatment, and I hereby assign to RMA all payments for services rendered to my dependents or myself.

SIGNATURE_____ DATE_____

PLEASE READ AND SIGN/INITIAL:

In order to keep your medical file up to date, we will be happy to provide your physician with a copy of our audiological findings. ***Please initial ONE*** ➔ Send a copy to my physician _____ (initial)
DO NOT send a copy to my physician _____ (initial)

I hereby give consent to the staff of RMA to render such care and treatment as might be required by my condition. I hereby authorize RMA to release information to any hospital, physician's office, or educational setting to whom I may be referred by/to this office and to obtain those medical records from other physician and medical facilities that may be pertinent and necessary to care and treat.

SIGNATURE_____ DATE_____