Robbi Hershon, Au.D., CCC-A *--- Doctor of Audiology, NJ Audiology License #451 – NJ Hearing Aid Dispensing License #917*
Debra Knapp, Au.D., CCC-A*--- Doctor of Audiology NJ Audiology License #404 – NJ Hearing Aid Dispensing License #767*

PATIENT REGISTRATION FORM

First Name: _____ Last Name: _____

Address: _____City: _____State:_____ Zip Code: _____

Phone #: _____Sex: _____ DOB: _____

Email: _____

Marital Status: _____ Employment Status: _____

Primary Physician: _____ Phone #:_____

Primary Insurance Company: _____ ID# _____

Secondary Insurance Company: _____ ID# _____

Name of Primary Insurance Holder: _____ Date of Birth:_____

Primary Insurance Holder's Employer: _____

Who referred you to our office? We like to know how our patients find our practice. If your physician, a family member, or a friend sent you in, we want to thank them. If you learned about our office another way, it is helpful that we know. Please check below the MOST influential sources of information about this practice. If it is your physician, an audiologist, a family member, or a friend, please provide their name. Thank You!

___ Physician ___ Vocational Rehabilitation ___ Health Plan/HMO ___ Audiologist ___ Yellow Pages
___ Seminar ___ Family Member ___ Newspaper ___ Internet ___ Friend/Co-worker ___ Hospital
___Mail ___Referral ___ Other: _____

Please provide the name of the person that referred you to our office (if applicable): _____

RELEASE OF MEDICAL INFORMATION

I,_____, hereby authorize The Hearing Group, LLC to release any and all medical information in the course of my (or my child's) treatment to:

PHYSICIAN _____
OTHER _____

IN ORDER FOR US TO FILE YOUR INSURANCE CLAIM THE FOLLOWING MUST BE SIGNED:

I authorize the release of any medical and/or other information necessary to process my medical claim. I also request payment of government benefits, either to myself or to the party who accepts assignment. Further, I authorize payment of medical benefits to be made directly to The Hearing Group, LLC for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself. If for any reason my insurance fails to make payment to The Hearing Group within 90 days, or pays only a portion, I will be responsible for balance in full at that time.

Patient/Parent/Guardian Signature: _____ Date: _____

MEDICARE PATIENTS ONLY: I request payment of authorized Medicare benefits to be made to The Hearing Group for any services rendered. I authorize any holder of medical information to be released to The Health Care Financing Administration and its agents. The provider agrees to accept Medicare assignment. The patient's responsibility will be for the deductible, coinsurance and other non covered services.

Name of Patient: _____Date: _____
Signature:_____

PRIVACY PRACTICES:
I have been given the opportunity to read or obtain a copy of the Notice of Privacy Practices.
_____ (Initials)