The Hearing Center

ADVANCED AUDIOLOGY CONCEPTS

Dr. Jane M. Kukula

Patient Information

Date ________________

Last Name ___________________ First _______________ Middle __________ Date of Birth __________

Mailing Address ___________________________________ City _______________ State _____ Zip ________

Home Phone ___________________ Work Phone ___________________ Cell ________________________

Age: _________ **Gender:** Male Female **Email:** ____________________________________

Marital Status: Single Married Divorced **Social Security Number:** ____________________________

Emergency Contact ______________________ Relationship _____________ Phone __________________

Primary Care Physician ______________________ How did you hear about us? ____________________

Insurance Information

Responsible party (the name insurance is issued under)

Last Name: __________________ First: ______________ Middle : ___________ Date of Birth: ________

Mailing Address: ________________________________ City: _______________ State: _____ Zip: _______

Home Phone ____________________ Work Phone ___________________ Cell: ______________________

Relationship to Patient _________________________ Social Security # ____________________________

Employer's Name ____

Does your health insurance offer a hearing aid benefit? ☐ **Yes** ☐ **No**

I hereby authorize Advanced Audiology Concepts, Inc. to submit claims for payment to my insurance company for payment. I request that payment of authorized benefits be made on my behalf to Advanced Audiology Concepts, Inc. for any service furnished to me. I authorize release of information about me to insurance companies if needed to determine payment for related services. I understand that I am responsible for balances such as co pays, deductibles and co-insurance amounts, as well as charges for uncovered services and/or products.

Signature X____ Date _______________

Signature X____ Date _______________

Signature X____ Date _______________

Signature X____ Date _______________

Signature X____ Date ______________

Signature X____ Date ______________

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Acknowledgement of Receipt of Privacy Practices Notice:

Patient Name: ______________________________

☐ Yes, I have been offered a hard copy of the Privacy Practices for my records

I give permission to Advanced Audiology Concepts to discuss issues related to my hearing, hearing instruments and other private health information with the following individual/s:

Name	Relationship to patient

X ____ ________________

Patient's Signature Date

____ ________________

Witness Signature Date

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