BETTER HEARING
REHABILITATION CENTER
BETTER HEARING IS A BETTER LIFE

www.betterhearingdurham.com T: 919-948-1947 F: 919-794-3047

Better Hearing Rehabilitation Center
Audiologic Services

14 Consultant Place
Suite 220
Durham, NC 27707

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Address (Street): _____

City: _____State:_____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Birth Date: _____ Age: _____ Male:_____ Female: _____

Social Security # _____ Patient's Occupation: _____

Email Address: _____

Employer: _____

Marital Status: Married____ Divorced____ Single____ Separated____ Widowed____

Spouses name: _____ Parent's Name (if under 18) _____

Referred by: _____

Primary Physician: _____ Phone # _____

Emergency Contact: _____ Phone # _____

How did you hear about us? (Please check one):

_____ Referred by Physician _____Referred by Friend/Family (name) _____

_____ Newspaper Ad (name) _____ _____ Phonebook _____Online _____Other:_____

Insurance Information (Please Submit Copies)

Primary Insurance: _____

Address: _____

Phone #: _____ Group ID#: _____ Insurance ID#: _____

Primary Cardholder: _____ Birthdate: _____ Relationship _____

Primary Cardholder's Employer: _____ Social Security #: _____

Address of Cardholder (if different from patient): _____

Secondary Insurance: _____

Address: _____

Phone #: _____ Group#: _____ ID#: _____

Primary Cardholder: _____ Birthdate: _____ Relationship _____

Primary Cardholder's Employer: _____ Social Security #: _____

Address of Cardholder (if different from patient): _____

NOTE: <u>The above area must be completed carefully and entirely for proper submission of your insurance claim. Failure to do so could result in non-payment of claims.</u>

SIGNATURE AUTHORIZATION

Better Hearing Rehabilitation Center, LLC is a privately owned company and all scheduling will be conducted through the practice. I understand that I am ultimately responsible for the balance on my account for any professional services rendered. BHRC will be happy to assist me in filing insurance, but I understand it is my responsibility to know and understand the rules and regulations of my specific plan, as well as what coverage is included on my plan. It is also my responsibility to contact my insurance carrier to determine if BHRC is in my specific network.

I authorize BHRC to release any information relating to the services obtained here and services related to my treatment to other professionals and insurers as may become necessary.

I understand that it is my responsibility to notify BHRC if I am unable to keep my scheduled appointment. Failure to give appropriate notice of cancellation may result in a "no show" fee for which I will assume responsibility. I also permit a copy of this authorization to be used in place of the original. I have read and agree to the above Signature Authorization section and comprehend that it will remain in effect until revoked by me in writing.

Signature: _____ Date: _____