Angela Batini, M.S., CCA-A

2510 Airpark Drive, STE C #101, Redding CA 96001

PATIENT INFORMATION

Patient's Name: ____

Parent Name (**IF Minor**) ____

Address: ____

City, State, Zip Code: ______________________ EMail: ______________________

Cell Phone: __________ Home Phone: ______________ Work Phone: ______________

Social Security: ____________ Birth Date: ____________ Sex: Male Female

Employer: ______________________ Student Fulltime Part Time

Referring Physician or Family Doctor: ______________________________

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I understand the Privacy Practices of Angela Batini's office and have been offered a copy for my information/records.

Signature: ______________________ Date: ______________

I authorize Angela Batini's office to leave a message on my answering machine/& send E-Mail. Yes / No __________ Initial:

I request that my primary care physician ______________ be provided with the information regarding my hearing loss and ongoing treatment. Yes / No __________ Initial: __________

Is there any family member(s) who you authorize us to speak with regarding your care?

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STATEMENT OF FINANCIAL RESPONSIBILITY:

It is the policy of this practice to collect the payment at the time of service. We will bill your insurance for services, however services cannot be rendered on the assumption that charges will be paid by your insurance. Your insurance is a contract between **YOU** and your insurance carrier. The responsibility for the full charges for your medical care are yours. Accounts that are 90 days past due will be sent to collections. In the event of default, I agree to pay all costs of collection and attorney fees. Initial: ____________

ASSIGNMENT OF BENEFITS:

I hereby authorize all benefits be paid to Angela Batini, M.S. for services rendered for myself or my dependents. I authorize the release of any medical information to secure benefits to secure payments of benefits for services rendered by Angela Batini, M.S. I understand that I am ultimately responsible for all charges. Initial: ____________

INSURANCE INFORMATION:

Primary Insurance: ______________________ Secondary: ______________________

Subscriber: ______________________ Date of Birth: ______________________

SIGNED: ______________________ Date: ______________________