PINNACLE AUDIOLOGY *Pinnacle Audiology*
605-306-4481
6809 S. Minnesota Ave., Suite 101 - Sioux Falls, SD 57108

PERSONAL INFORMATION

Today's Date: _____ Male Female Other (please circle)
Name: _____ Date of Birth: _____
Guardian's Name if under 18: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Cell Carrier: _____
Work Phone: _____ Place of Employment: _____
Email Address:_____ May we send you email? No Yes
Marital Status: Married Single (please circle) Spouse's Name if applicable: _____

CONTACT METHOD (FOR PRIVACY)

Keeping in mind that cell phones, txt messages, and email are not completely secure, please indicate one or more methods by which you prefer to be contacted by this office:

___ Home phone ___ Cell phone ___ Txt message ___ Work phone ___ Email ___ Mail to home
___ Other (example contact family member): _____

If you want to have billing statements and/or other correspondence from this office sent to an address other than your home, please list it here: _____
_____

REFERAL INFORMATION

Who referred you or how did you hear about this clinic? _____
Primary Care Physician: _____ Phone: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

By signing this document, I hereby acknowledge that I have received, or was offered and declined to take a copy of the Notice of Privacy Practices of Pinnacle Audiology, LLC.

Patient or Guardian Signature: _____ Date: _____

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INSURANCE INFORMATION

Please fill out the information below and provide your insurance cards for copying to assist in billing your insurance company for you.

Primary Insurance Co.: _____ Secondary Insurance Co.: _____

Subscriber's Name: _____ Subscriber's Name: _____

Subscriber's Date of Birth: _____ Subscriber's Date of Birth: _____

Subscriber's Employer: _____ Subscriber's Employer: _____

CONSENT TO TREATMENT, ASSIGNMENT & FINANCIAL AGREEMENT

Assignment, Release & Financial Agreement: I authorize treatment of person named above by Pinnacle Audiology, LLC and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to Pinnacle Audiology, LLC and I am financially responsible for non-covered services. I further agree the account is to be paid in full at the time of service unless other arrangements have been made. Should the account be referred to a collections agency or an attorney for collection, I will pay all reasonable collection agency or attorney fees and court costs. I also authorize the release of medical information to other health care providers, my insurance company, Medicare or any third party payer to facilitated health care, processing of claims and audit payments.

Patient or Guardian Signature: _____ Date: _____