Aspire
HEARING & BALANCE

635 Mid-Florida Dr, Suite 2
Lakeland, FL 33813
O: 863-646-3277
F: 863-646-3299
AspireHearing.com

PATIENT REGISTRATION

To fill out this form and print, open in Adobe Reader or your web browser of choice.

1. PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. Today's Date: _____

First Name: _____ M.I.: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: (____) _____-_____ Home Phone: (____) _____-_____ Work Phone: (____) _____-_____

Email: _____ Preferred Name: _____

Sex: ☐ Female ☐ Male Date of Birth: ___/___/_____ Social Security #: _____

Language: _____ Occupation: _____ Employer: _____

Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Child ☐ Partner

Primary Care Physician: _____ Phone: (____) _____-_____

Emergency Contact: _____ Relation: _____ Phone: (____) _____-_____

*If the patient is under the age of 18, please give the following information:

Parent/Guardian's Name: _____ Phone: (____) _____-_____

How did you hear about our office? _____

2. INSURANCE INFORMATION

Primary Insurance Company: _____ ID #: _____

Insurance Policy Holder: _____ Date of Birth: ___/___/_____

Relation to Patient: _____ Social Security #: _____

Policy Holder Employed by: _____

Secondary Insurance Company: _____ ID #: _____

In order for us to file your insurance claim for you, 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 that payment of government benefits, be made to either myself or to the party who accepts assignment. Further, I authorize payment of medical benefits to be made directly to Aspire Hearing and Balance, LLC for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

Patient/Parent/Guardian Signature: _____ **Date**: ___/___/_____

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SIGNATURE FORM

PERMISSION FOR TREATMENT

Permission is hereby granted for audiologists, audiologists in training, or employees of Aspire Hearing and Balance LLC to render such medical treatment as is deemed necessary.

ASSIGNMENT OF INSURANCE BENEFITS

I authorize my insurance company to pay and hereby assign directly to Aspire Hearing and Balance LLC all benefits, if any, otherwise payable to me for services as described on the attached forms.

I further expressly agree and acknowledge that my signature on this document authorizes my audiologist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, that I will be bound by this signature as though the undersigned has personally signed the particular claim. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Aspire Hearing and Balance LLC, will be credited to my account in accordance with the above said agreement.

HIPAA PRIVACY NOTICE

I have been given the opportunity to read or obtain a copy of the "HIPAA - Your Rights" Privacy Notice.

FINANCIAL RESPONSIBILITY

I have been given the opportunity to read or obtain a copy of the the "Patient Financial Responsibility Acknowledgment" Notice.

SHARING YOUR INFORMATION

If you choose, please list by name and relationship the persons with whom we may share your healthcare or payment information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

The undersigned has read and agrees to the information stated above:

- Permission for Treatment
- Assignment of Insurance Benefits
- "HIPAA - Your Rights" Privacy Notice
- "Patient Financial Responsibility Acknowledgment" Notice

Print Name of Patient/Parent/Legal Guardian: _____

Signature of Patient/Parent/Legal Guardian: _____ **Date**: ___/___/_____