Northwest Florida ENT

561-848-8000
Fax: 561-848-8001

www.audiology.pro eardoc@audiology.pro 927 Main St., Suite 101 - West Palm Beach, FL 33407

Date: 12/30/2012 **Audiologist: AH**

Personal Information

Last Name	First	MI	Age	Birth Date
Smith	**Robert**	**L.**	**69**	**3/2/1943**

Street	Occupation
4506 45th WY	

City	State	Zip	Employer
Mangonia Park	**FL**	**33407**	

Home Phone	Cell Phone
(333) 444-5555	**(918) 599-7352**

Company	Company Phone

Family Physician	Physician Referred By
Dr. Susan Elwell	**Dr. Nicole M Bassig**

Physician Street	Physician Street
3673 Delaware Avenue	**3725 North Buffalo Rd**

Physician City	State	Zip	NPI	City	State	Zip	NPI
Sacramento	**CA**	**94297**	**1234567797**	**Rohnert Park**	**CA**	**94927**	**1336349760**

Referral Source	Referral Detail
Newspaper	**Half Page Ad**

Insurance Information

Primary Insurance	Primary ID#
AARP UnitedHealthcare Insurance Co.	**36273**

Secondary Insurance	Secondary ID#
Alaska Pipe Trades Local 375	**91136**

Receipt of Notice of Privacy Practice - Written Acknowledgment Form

I, Robert L. Smith, have received a copy of Hearing Evaluation Services's Notice of Privacy Practices.
You may discuss My Protected Health Information with the Following Parties:

_____

_____ _____

Signature of Patient Date

Hearing Evaluation Services may participate with my insurance however, Hearing Evaluation Services does not participate with **MEDICAID**. I understand that all deductibles, copays and services not covered by my insurance company, are my responsibility. If I fail to obtain a valid and current referral and/or script, I am responsible for payment of any charges. Hearing Evaluation Services will file insurance claims on my behalf. I also understand that as a part of my treatment, payment or healthcare services, it may become necessary to disclose my health information to another entity and I consent to such disclosure for these permitted uses, including via fax. I authorize payment of medical benefits to the undersigned supplier for services.

_____ _____

Signature of Patient Date

[ ] Patient refused to sign/read. _____Initials _____/_____/_____ Date