

Legal name: Preferred name:  
 DOB: Gender: Preferred method of contact:  
 Home phone: Cell phone: Work phone:  
 OK to leave voicemail? OK to text?  
 Address:  
 City: State: Zip code:  
 Email address: OK to email?

**INSURANCE INFORMATION**

PRIMARY INSURANCE		SECONDARY INSURANCE	
Insurer name		Insurer name	
ID		ID	
Group		Group	

**PHYSICIAN INFORMATION**

Primary clinic name: Clinic phone number:  
 Physician's name:  
 Clinic address:  
 Send audiology report to physician?

Please list other individuals we can talk to or leave a message with about your healthcare or results.

Name		Relationship		Phone		Email	
Name		Relationship		Phone		Email	

- I certify that the information provided above is correct.
- I hereby authorize insurance submissions and direct payment of any medical benefits for services provided to be sent directly to Axe Audiology. I further authorize the release of information to primary/secondary insurance companies.
- I consent to the usage of a copy of this authorization in place of the original.
- I understand that I am ultimately responsible for the balance on my account for services rendered, and it is my responsibility to know the rules and regulations of my health insurance, as well as what coverage is included with my specific plan.

I acknowledge that, in compliance with the Health Insurance Portability  
 Accountability Act (HIPAA), a Notice of Privacy Practices has been presented to me  
 and I understand that a paper copy is available upon request. (Please mark the box)

Signature:

Date of Completion: