# *REGISTRATION FORM (PLEASE PRINT)*

| **Today's date:** | **Family Doctor:** |
|---|---|

## PATIENT INFORMATION

| Patient's last name: First: Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid |
|---|---|---|---|

| Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ❑ M ❑ F |
|---|---|---|---|---|---|
| If married, Spouse's Name: | | | | | |

For Appointment reminders or call-back requests: OK to leave messages on answering machine, voice mail or with family members? ❑Yes ❑No

| Street address: | | Home phone : ( ) |
|---|---|---|

| City: | State: | ZIP Code: | Cell phone : ( ) |
|---|---|---|---|
| Occupation: | Employer: | | Work phone : ( ) |

**EMAIL ADDRESS**: _____ *How often do you check your email?* _____

| **Referred to Trinity Hearing Care, LLC by (please check one box):** | **❑ Dr.** | **❑ Yellow Pages/Online** | **❑ Close to home/work** |
|---|---|---|---|
| **❑ Family** _____ | **❑ Friend** _____ | **❑ Advertisement** _____ | |

## FINANCIAL POLICIES

- Payment is **due at the time of service unless other arrangements have been made in advance.**
- There will be a $25 fee for all returned checks.
- In fairness to other patients and the physician, we request 24 hours notice to cancel an appointment.
- **I agree to the above financial policy. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees.**

## AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I consent to the use or disclosure of my protected health information (including audiograms) by Trinity Hearing Care, LLC and/or Dr. Julie K. Barth for the purpose of diagnosing or providing hearing care & treatment to me.

I understand that diagnosis or treatment of me by Trinity Hearing Care, LLC and/or Dr. Julie K. Barth may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out hearing care and treatment. Trinity Hearing Care, LLC and/or Dr. Julie K. Barth is not required to agree to the restrictions that I may request. However, if Trinity Hearing Care, LLC and/or Dr. Julie K. Barth agrees to a restriction that I request, the restriction is binding on Trinity Hearing Care, LLC and/or Dr. Julie K. Barth.

I have the right to revoke this consent, in writing, at any time, except to the extent that Trinity Hearing Care, LLC and/or Dr. Julie K. Barth has taken action in reliance on this consent.

My "protected health information" ("PHI") means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to Trinity Hearing Care, LLC's and/or Dr. Julie K. Barth's use or disclosure of my PHI for purposes of delivering relevant product and/or technology marketing communication to me.

I acknowledge that Provider may receive financial remuneration from the manufacturer in connection with such communications.

## IN CASE OF EMERGENCY

| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( ) |
|---|---|---|---|

**The above information is true to the best of my knowledge. I understand that I am financially responsible for any charges incurred.**

## SIGNATURE

**I have read and agree to the above policies:**

**Signature of Patient or Guardian** **Date**