AMAZING HEARING
changing how you hear

PATIENT INFORMATION

24251 Avenida De La Carlota B-1
Laguna Hills, CA 92653

INFORMATION

Date _____

Name _____ _____ _____
First Middle Last

Address _____

City _____ ST _____ Zip _____ Date of Birth _____

Home # _____ Cell # _____ Email _____

ALTERNATE CONTACT INFORMATION

Name _____ _____ _____
First Middle Last

Phone Number _____ Email _____ Relationship to patient _____

REFERRAL INFORMATION

Who referred you or how did you find out about us? _____

Primary Care Physician _____ CITY _____

PATIENT HIPAA CONSENT

I understand that I have certain rights to privacy regarding my protected health information according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize the Clinic to use and disclose my protected health information for the purpose of:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- The day-to-day healthcare operations of the clinic such as quality assessments and provider certifications.

PATIENT SIGNATURE

Patient signature or legal custodian

_____
Please Sign Here Self or Relationship to Patient

_____
Print Name Date

ALL CHARGES REMAIN THE REPSONSIBILITY OF THE PATIENT.