



Julie E. Eschenbrenner, Au.D.  
Doctor of Audiology

## Patient Information

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
(first) (initial) (last)

Street Address: \_\_\_\_\_ Age: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-mail: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## Responsible Party Information

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Referral Information

Reason for Initial Consultation: \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Primary care physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Other Care Providers: \_\_\_\_\_ Phone: \_\_\_\_\_

### Insurance/Billing Information

Insurance Company: \_\_\_\_\_ Subscriber # \_\_\_\_\_

Group Name: \_\_\_\_\_ Group # \_\_\_\_\_

Insurer: \_\_\_\_\_ (primary person with insurance policy) Date of Birth: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ SSN: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Please provide cards for us to copy.



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**Patient Agreement with Flatirons Audiology, Inc.:**

**I understand that payment is due at time of service but, as a courtesy to me, Flatirons Audiology, Inc. will submit claims to my insurance carrier for audiological testing. I authorize payment of insurance benefits to Flatirons Audiology, Inc. and acknowledge that I am responsible for payment of services denied or not covered by my insurance company.**

**I acknowledge that I am responsible for submitting my current insurance company.**

**I may decline to bill insurance and self pay at the time of service.**

**I acknowledge that I have reviewed a copy of HIPPA Notice of Privacy Practices.**

**I give permission to Flatirons Audiology, Inc. to bill for services provided to me and authorized by Medicare and/or the insurance company listed above. I authorize medical information about me to be disclosed as needed for determination of benefits payable for related services. I assume responsibility for payment of services not covered by my insurance.**

**Signature of Patient or Legal Guardian:**

\_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_