



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

Patient Information

Name: _____ Date of birth: _____
Street Address: _____ Age: _____
City: _____ State: _____ Zip: _____ E-mail: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Employer: _____ Occupation: _____
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: _____