Hearing Associates Inc

1830 Blake Avenue Suite 203 Glenwood Springs, CO 81601
310 Market Street Suites 112-113 Basalt, CO 81621

Patient Information- Please Print

Date ____________________________ Referred By ____________________________

First Name ____________________________ Middle ____ Last Name ____________________________

Home Phone ___________________________ Cell Phone ____________________________

Address ______________________________________ City ___________________________ Zip ________

Spouse Name ____

Email ____

Birthday ______________________________________ Male / Female Single / Married / Widowed

Primary Physician ____

Please check all that apply:

Appointment Reminders Preference ______Email ______Phone _____ Text

Is this your first hearing test? ____________ Do you wear hearing aids? _____________

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Appointment Agreement

Comprehensive Audiometric Test - $148
Cerumen Removal - $40 per ear
Dix Hallpike Procedure - $55
Initial Canalith Repositioning Treatment - $88
Follow-Up Canalith Repositioning Treatment - $62
Office Visit - $45.00 (30 Minute Appointment)

***CANCELLATIONS/NO SHOW:** Prepayment of $148.00 may be required at time of rescheduling an appointment after several cancellations/no show.

I am aware and responsible for all financial obligations of health services for the above patient.

Signed X ____

I authorize release of information in my medical history to my primary physician.

Signed X ____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ______________________________________

Date of Birth: ______________________________________

Social Security Number: ______________________________

Phone Number: ______________________________________

I acknowledge that I received a copy of Hearing Associates' Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, the website (if applicable) and that I will be offered a copy of any amended Notice of Privacy at each appointment.

- This Notice informs me how Hearing Associates will use my health information for the purposes of my treatment and or payment for my treatment.

- This notice explains in more detail how Hearing Associates may use and share my health information for other than treatment, payment, and health care options.

- Hearing Associates will also use and share my health information as require/permitted by law.

______________________________________ ________________

Printed Name of Patient or Personal Representative Date

______________________________________ ________________

Signature of Patient or Personal Representative Date