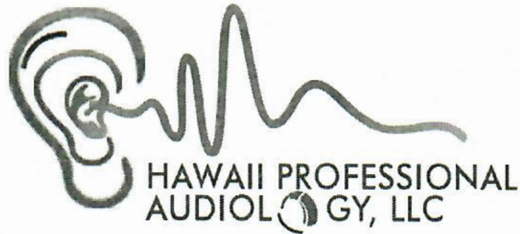

Last Name: ______________________ First Name: ______________________ MI: ___________

Date of Birth: ____________________ Age: ____________ SSN: __________________________

Adult: Male: _____ Female: _____ Marital Status: M S W D Child: Male: _____ Female: _____

Billing Address: ____

City: ____________________________ State: _________________ Zip Code: ________________

Phone: ___________________________ Cell: __________________ Work: __________________

Employer or School: ____

Referred By: ___________________________ Primary Care Doctor: ____________________________

Contact Person: ________________________ Relationship: ______________ Phone: _____________

Preferred Method of Contact: □ Phone □ Email: ____

IF PATIENT IS A MINOR

Parent or Guardian's Name: __________________________ Relationship to Child: _______________

ASSIGNMENT AND RELEASE:

I hereby authorize my insurance benefits to be paid directly to Hawaii Professional Audiology, LLC (HPA, LLC), if applicable. I also authorize HPA, LLC to release reports/results obtained by HPA, LLC to my referring doctor, agency, organization, or clinic.

NOTE:

I acknowledge and understand that I am responsible for all of the charges for service(s) rendered to me. Although HPA, LLC will bill my insurance, I clearly understand that it is still my responsibility to make sure the bill is paid within a reasonable time. After the patient's insurance has made payment and co-pay by the responsible party is due, an invoice will be submitted. If payment is not received by HPA, LLC within 30 days from date of invoice, a one-time Service Fee of $5.00 will be charged along with a monthly late fee of 1.5%.

SIGNATURE: ____ Date: __________________________

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