1520 Wakarusa Drive
Suite B
Lawrence, KS 66047
www.kawvalleyhearing.com

# Patient Information Form

Name:_____________________________________________ Date of Birth:____/____/_____ Age:_________
First MI Last

Address:__________________________________________________________________________________________
Street Apt# City State Zip

Primary Phone #:______________________________ Social Security # ____________________________
Other Phone #: _______________________________ Email Address: ______________________________
Employer Name: ______________________________ Employer Phone #:___________________________
Emergency Contact:_________________________________________________________________________
Name Phone Number Relationship

**SPOUSE INFORMATION REQUIRED IF YOUR SPOUSE IS THE PRIMARY POLICY HOLDER OF YOUR INSURANCE**

Spouse Name:________________________________ Daytime Phone#______________________________
Spouse Employer:______________________________ Date of Birth:______/______/________
Spouse Social Security #:__________________________

**PLEASE COMPLETE THIS SECTION IF A PATIENT IS A MINOR ( under 18 years of age)**

Father's Name:__________________________ Mother's Name:____________________________
Social Security #:_________________________ Social Security #:__________________________
Date of Birth: ___/____/_____ Date of Birth: ___/____/______
Home Phone: ___________________________ Home Phone: ____________________________
Employer: ______________________________ Employer: ________________________________

**WHO REFERRED YOU TO THIS OFFICE?**

Physician: ____________________________ Internet Newspaper/Magazine
Friend/Family:__________________________ Yellow Pages Insurance
Other: ________________________________ Mailing Radio

**RELEASE OF MEDICAL INFORMATION**

Primary care physician ____________________________________________________________________
Name City Phone

I, _____________________, hereby authorize Kaw Valley Hearing to release any and all medical information in the course of my (or my child's) treatment to the physician(s), person or organization listed above.

_______________________________________ ____/_____/________
Signature of Patient, Parent or Guardian Date

**NOTICE OF RESPONSIBILITY**

I understand that if I do not have insurance or my insurance is not accepted by Kaw Valley Hearing, I need to make payment, *in full*, at time of service. Kaw Valley Hearing will file my insurance claim for me; however, this does not guarantee that my insurance will pay in full, and I will be responsible for payment of any remaining balance due.

Kaw Valley Hearing accepts payment by Cash, Personal Check, Money Order/ Cashier's Checks, MasterCard, Visa, Discover, American Express and KATCO Financing Option. If other arrangements are necessary, I will discuss them with the office staff before I am examined by the audiologist. A returned check fee of $30.00 will be applied to the patient's account which issued the check.

_______________________________________ ____/_____/________
Signature of Patient, Parent or Guardian Date

**IN ORDER FOR US TO FILE YOUR INSURANCE CLAIM FOR YOU, THE FOLLOWING MUST BE SIGNED:**

I authorize the release of any medical and/or other information necessary to process my medical claim. I also request payment of government benefits, either to myself or to the party who accepts assignment. Further, I authorize payment of medical benefits, to be made directly to Kaw Valley Hearing for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

_______________________________________ ____/_____/________
Signature of Patient, Parent or Guardian Date