



Patient Intake Form

Last Name:		First Name:		Middle Name:	
Birth Date:		Phone #1:		Phone #2:	
Sex:	SSN:		E-Mail:		
Address:			City/State/Zip:		
Employed By:				Work #:	
Name of Closest Family Member:				Relation to you:	
Family Members Phone #:		May we contact them?		Yes	No
Primary care Physician:				Phone Number:	
Would you like a copy of your hearing test results sent to the above mentioned provider or another physician?				Yes	No
Other Physician's Name:					
Whom may we thank for referring you to our office?					

Insurance & Payment Information					
Primary Insurance:				Insurance ID#:	
Name of Policy Holder:				Policy #:	
Secondary Insurance:				Insurance ID#:	
Who is financially responsible for this visit?				Phone #:	
I will pay today by:		Cash	Check	Credit Card	Other #

I authorize The Advanced Hearing Center, having treated me, to release to governmental agencies, insurance carries, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such treatment. Upon my request for release of my medical records, I hereby authorize The Advanced Hearing Center to furnish all records and results to parties I specify.

Signature: _____

Date: _____

Parent Signature if Minor: _____

Date: _____

Advanced Hearing Center

Albertson (516-484-0811) 1163 Willis Avenue, Albertson, NY 11507
Brooklyn (718-858-6734) 161 Atlantic Ave, Suite 1, Brooklyn Heights NY
Manhattan (212-734-8900) 329 East 68th Street, New York, NY 10065
Manhattan West Side (718-858-6734) 10 West 74th Street Apt 11, New York, NY 10023
Manhattan (212-734-8900) 201 East 65th Street New York, NY 10065
North Shore Towers (516-484-0811) 26910 Grand Central Parkway, A-5 Floral Park, NY 11005

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

ADVANCED HEARING CENTER'S LEGAL DUTY

Advanced Hearing Center is required by law to protect the privacy of your personal health information, provide this notice about our information practices and below the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Advanced Hearing Center uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Advanced Hearing Center may use your personal health information to provide appointment reminders or information about treatment alternatives or other health related benefits that could be of interest to you.

Advanced Hearing Center may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Advanced Hearing Center's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time. Advanced Hearing Center may change its policy at any time. When changes are made, a new Notice of Privacy Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Privacy Practices at any time.

YOUR INDIVIDUAL RIGHTS:

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Advanced Hearing Center will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you think that we may have violated your privacy rights, please contact our practice manager at the address below. You may also send a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human services. We will not retaliate in any way if you choose to file a complaint.

I _____, have read all of the above and understand this Notice of Privacy Practices regarding my personal health and have received a copy of this notice for my personal records.

Signature of patient or guardian

Date