Kentucky Audiology and Tinnitus Services, PLLC

PATIENT INFORMATION

Kentucky Audiology and Tinnitus Services, PLLC is not in network with any insurance companies. Payment is required at the time of service. We will gladly file the claim with your insurance company. The insurance company will reimburse you if any of the procedures are covered expenses.

NAME:_____ **DATE:** _____

Parent's Name if under 18 _____

ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

HOME PHONE:_____ **CELL PHONE:**_____

DATE OF BIRTH:_____ **E-MAIL:**_____

PLACE OF EMPLOYMENT _____

How did you hear about us? _____

INSURANCE PROVIDER: _____

NAME OF PERSON WHO CARRIES INSURANCE: _____ **DOB:** _____

FAMILY PHYSICIAN: _____

Would like us to send a report of today's findings to your family physician? YES☐ **NO** ☐

If yes, please provide the address: _____

May we speak to your family physician in regards to your care? YES☐ **NO** ☐

Do you have legal action pending in relation to your tinnitus/sound tolerance, or are you planning legal action? NO ☐ **YES** ☐

I authorize Kentucky Audiology & Tinnitus Services, PLLC to release information requested with regard to processing my insurance claims. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Kentucky Audiology & Tinnitus Services, PLLC of any changes in my health status or in the above information.

Patient Signature: _____ **Date:** _____