# Mayflower Hearing Care, LLC

Name________________________________ Date of Birth_________________

Address__________________________________________________________

Marital Status________________ Phone Number_________________________

Cell phone_________________ Email_________________________________

How did you hear about us? __________________________________________

## Insurance Information

Primary Insurance Company__________________________________________

Subscriber Number___________ DOB(cardholder)_______________________

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Emergency Contact____________________ Phone_______________________

Relationship___________________

Name of Primary Physician______________ Address______________________

City__________________ State_______ Zip_________ Phone_____________

I understand that I am financially responsible for payment of services rendered by Mayflower Hearing Care, LLC. I request that payment for authorized insurance benefits and or Medicare benefits be made to me or on my behalf to this doctor. I authorize any holder of medical information to release to the appropriate agents any information needed to determine these benefits payable for related services. A copy of my signature is as good as the original. My practice is committed to securing the privacy of your health information. You are not required to read the practice's Notice of Privacy Practice, but it is available to you. However, we would like your acknowledgement that you have been notified that the practice has such a Privacy Practice Notice. Within the guidelines of HIPPA, patients will be sent post cards for follow up and reminders. Please contact the office if you have any questions about our policies.

Signature___________________________________ Date_________________