WELCOME

The benefits of hearing are immeasurable. Our primary goal is to provide you with the very best personalized hearing care. We will work with you until you are satisfied with your hearing abilities. Gulf Coast Audiology is dedicated to serving your needs in an honest and attentive manner.

PATIENT INFORMATION

DATE _____

PATIENT NAME _____

ADDRESS _____
STREET CITY STATE ZIP CODE

HOME PHONE _____ CELL PHONE _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

E-MAIL ADDRESS _____

STATUS ☐ MARRIED ☐ SINGLE ☐ WIDOW ☐ DIVORCED ☐ CHILD

EMPLOYED ☐ YES ☐ NO EMPLOYER _____

EMPLOYER'S ADDRESS _____
STREET CITY STATE ZIP CODE

EMPLOYER'S PHONE _____

CONTACT PERSON *(OTHER THAN PATIENT)* ☐ SPOUSE ☐ RELATIVE ☐ FRIEND ☐ GUARDIAN

NAME _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? _____

PRIMARY CARE PHYSICIAN _____

ADDRESS _____
STREET CITY STATE ZIP CODE

TELEPHONE _____

ARE YOU A SEASONAL RESIDENT? ☐ YES ☐ NO

FLORIDA SEASONAL DATES: FROM _____ UNTIL _____

ALTERNATE ADDRESS _____
STREET CITY STATE ZIP CODE

ALTERNATE TELEPHONE _____

OVER

INSURANCE VERIFICATION FORM

Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____

Effective Date_____

Spouse/Family Member Policy Holder Name_____DOB_____Relation To Patient_____
(If Other Than Patient)

Insurance Company_____ID#_____ GRP#_____

Claims Mailing Address:_____ Ins Co. Phone:_____

Deductible? Yes__ No___ How Much?_____Has Deductible Been Met_____If Not How Much Left?_____

Co-Pay? Yes__No__ How Much?_____In Network?_____Out Of Network_____

Are We A Participating Provider?_____Our Provider #_____

Hearing Aid Coverage?___Yes___No___If So How Much?_____How Often?_____

Does Patient Need To Be Referred By ENT?_____Primary Care Doctor?_____

Hearing Testing Benefits?_____Does Deductible Apply?_____ Co-Pay_____

SIGNATURE ON FILE AND AUTHORIZATION

I UNDERSTAND THAT THE INFORMATION I HAVE GIVEN TODAY IS CORR ECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE AND IT IS MY RESPONSIBILTY TO INFORM THIS OFFICE OF ANY CHANGES.

I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR ALL FEES CHARGED BY GULF COAST AUDIOLOGY, FOR SERVICES AND PRODUCTS. I UNDERSTAND THAT FEES ARE PAYABLE UPON RECEIPT OF SERVICES UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

I AUTHORIZE THE AUDIOLOGY STAFF TOPERFORM ANY NECESSARY AUDIOLOGICAL SERVICES THAT I MAY NEED DURING DIAGNOSIS AND TREATMENT WITH INFORMED CONSENT.

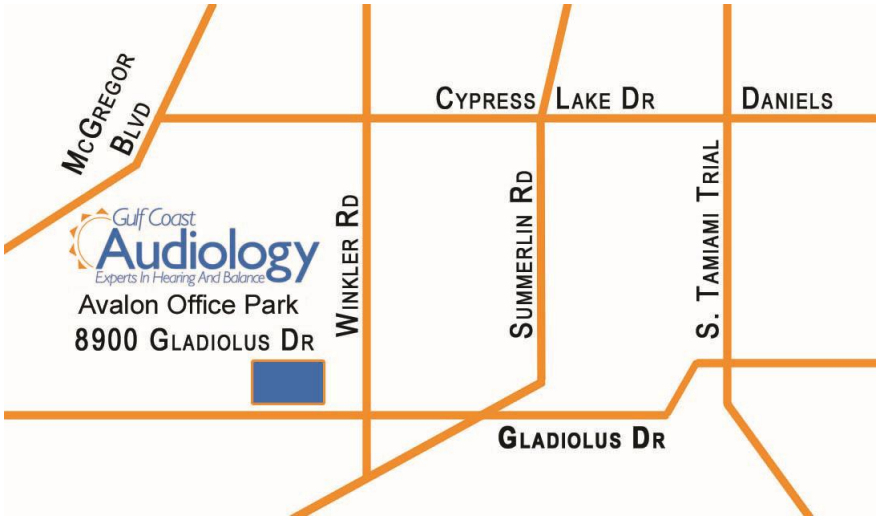
I AUTHORIZE PAYMENT OF INSURANCE/MEDICARE BENEFITS TO THE UNDERSIGNED AUDIOLOGIST FOR SERVICES RENDERED, DR. DRIANIS DURAN, AuD. GULF COAST AUDIOLOGY.

I AUTHORIZE GULF COAST AUDIOLOGY TO RELEASE TO MY INSURANCE COMPANY AND/OR THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS FOR RELATED SERVICES.

_____ _____

PATIENT SIGNATURE DATE

Map & Directions



Park on the left side of building. We are on the second floor in Suite 201. The elevator is located adjacent to the stairs for your convenience.

From McGregor:
Turn onto Gladiolus Dr. and head east. Drive past Bass Rd. and Parker Lakes Dr. Turn left into the Avalon Office Park

From Summerlin:
Turn onto Gladiolus Dr. and head west. Drive just past Winkler Rd. and turn right into the Avalon Office Park.

From 41:
Turn onto Gladiolus Dr. and head west. Drive just past Winkler Rd. and turn right into the Avalon Office Park.

PRIVACY PRACTICES ACKNOWLEDGEMENT

Gulf Coast Audiology
8900 Gladiolus Drive, Suite 201
Fort Myers, Florida 33908
Telephone: 239-267-7888
Fax: 239-267-0409

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my Audiologist's ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such ***Notice of Privacy Practices.*** I understand that my Audiologist has the right to change the ***Notice of Privacy Practices*** and that I may contact this office at the address above to obtain a current copy of the ***Notice of Privacy Practices***.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____
(If Applicable)

.....

FOR OFFICE USE ONLY:
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign

☐ Communication barriers

☐ Emergency situation

☐ Other