Lafayette
Zachary
Crowley

Toll Free 877-358-6130

Last Name: ________________________________**First:** ___________________________________**M.** __________

Address: ____

City: _________________________________**State:** ____________________________**Zip Code:** ________________

Home #_______________________ **Work #**________________________ **Cell #**______________________________

Date of Birth: _______________________**Social Security #**___________________________**Sex: Male / Female**

E-Mail Address: ______________________________________ **Marital Status:** Married Single Widowed Divorced

Employer/Student Status: Full Part Time Retired Not Employed **Primary Care Physician**_____________________

Responsible Party Name______________________________ **D.O.B.** ___________________ **Phone#**______________

Address:_____________________________**City**______________________**State**________**Zipcode**________________

Emergency Contact: ________________________**Phone:** ______________________**Relationship**_______________

How did you hear of our services: ____

Insurance

Primary________________________________ **Policy #**________________________ **Grp. #**_________________

Insured's name: ____ **Date of Birth:**____________

Relationship to Insured________________________________ **Employer**_________________________________

Notice of Privacy Practices Written Acknowledgement Form

_____________________________has received a copy of **selective** hearing's **Notice of Privacy Practices.**
(Patient)
Signature of patient or Guardian ____ Date: ______________

I hereby assign, transfer, and set over to **selective**hearing all of my right, titles, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits.This authorization shall remain valid until I give written notice revoking the said authorzation. **I understand that I am financially responsible for all charges whether or not they are covered in insurance.** This authorization is also valid for release of medical records concerning my illness and treatment.

Signature: ____ **Date**__________________________________