Lagniappe HEARING

Angela Ponthier, Au.D.

PATIENT INFORMATION

Patient Name _____
First MI Last

DOB: _____ /_____ /_____ SSN: _____ /_____ /_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Work Phone: (____) _____ Occupation: _____

E-Mail: _____

Preferred method of contact: _____ Marital Status: _____

Emergency Contact: _____ Phone: (____) _____

Primary Care Provider: _____

How did you hear about us? _____

I assign directly to Lagniappe Hearing all healthcare benefits otherwise payable to me for services rendered. I further authorize and direct all responsible insurance companies to make all checks payable to Lagniappe Hearing. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment from my health insurance carrier. Furthermore, I do hereby grant to any officer or designated employee of Lagniappe Hearing the right to endorse for me and in my name, place and stead all checks related to the services provided to me by Lagniappe Hearing. I have been presented with a copy of Lagniappe Hearing's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law.

_____ _____
Signature Date