

Personal History

a member of **AUDIGY GROUP**SM

Your Experience

We believe in, and strive to provide, a convenient location with ample parking and expect our staff to always be professional, courteous and helpful. To provide you with the highest level of service, please rate your experience of the following areas.

- | | | | |
|----------------------------------|------------------------------------|----------------------------------|-------------------------------|
| Location and accessibility | <input type="checkbox"/> Excellent | <input type="checkbox"/> Average | <input type="checkbox"/> Poor |
| Adequate parking | <input type="checkbox"/> Excellent | <input type="checkbox"/> Average | <input type="checkbox"/> Poor |
| Convenience of appointment times | <input type="checkbox"/> Excellent | <input type="checkbox"/> Average | <input type="checkbox"/> Poor |
| Friendly greeting | <input type="checkbox"/> Excellent | <input type="checkbox"/> Average | <input type="checkbox"/> Poor |
| Clean and welcoming environment | <input type="checkbox"/> Excellent | <input type="checkbox"/> Average | <input type="checkbox"/> Poor |

What can we do to make your next visit more comfortable?

*******PLEASE READ CAREFULLY AND SIGN BELOW*******

- I give permission to my AudigyCertified™ practice to release information, verbal and written, contained in my medical record and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.
- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
- I authorize the Hearing Assessment Center, Inc. to bill my insurance and I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.
- I have read all the information on this sheet and have completed the above answers, certify this information is true and correct to the best of my knowledge and hereby give my AudigyCertified practice permission to treat my concerns.
- The FDA has determined that it is in my best health interest to have a medical evaluation by a licensed physician (preferably a physician who specializes in diseases of the ear) before purchasing hearing instruments. I have been advised by my AudigyCertified practice and/or its agents about this determination and hereby waive this requirement.

I have read and understand all the above information.

A copy of this signature is as valid as the original.

Date

Signature of parent or guardian if patient is a minor: _____