TINNITUS AND HYPERACUSIS CLINIC

Patient Information Form

Last Name:	**First Name:**	**Middle Name:**
Address:		**City/State /ZIP:**
Primary Phone:	**Type:**	**Other Phone:** / **Type:**
Date of Birth:	**Gender:**	**Email:**
Family Contact:	**Relationship:**	**Phone:**
How did you hear about our clinic?		
Primary Care Physician:	**Clinic:**	
Clinic Address:		
Your ENT:	**Clinic:**	
ENT Address:		
I give consent to release the results of my testing to my Primary Care Physician and to My ENT listed above: **Yes:** ☐ **No:** ☐		
Are you currently seeking any form of compensation, sickness benefit, DVA, motor vehicle accident claim or any other legal action in relations to your tinnitus, hyperacusis, or misophonia? **Yes:** ☐ **No:** ☐		

TO OUR PATIENTS: OUR FINANCIAL POLICY

Thank you for choosing us as your hearing health care provider. We are committed to your hearing health care needs. Please understand that payment of your bill is considered part of your service. The following is a statement of our Financial Policy, which we require you to read and sign prior to any service.

REGARDING PAYMENT

All fees are payable at the time of service. This includes, but is not limited to: initial counseling, directive counseling, Tinnitus Retraining Therapy instruments, hearing aids, musician plugs, hearing protection, and the fitting, programming, and education on use of instrumentation.

Fees will be collected at the time of service

I have read the Financial Policy and I verify that the information provided above is accurate and understood to the best of my knowledge: _____ Date:_____

(Signature of Patient or Responsible Party)