



# Patient Information Form

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?

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## Insurance Information

*Please give your insurance information and identification to our front office staff so we can make a copy for our records.*

*Please read carefully and sign below (please note **highlighted boxes are recommended**)*

- I give permission to my AudigyCertified™ practice to release information, verbal and written (contained in my medical record and other related information), to my:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Insurance Company | <input type="checkbox"/> Related Healthcare Providers | <input type="checkbox"/> Family, Assignees, Beneficiaries |  |
| <input type="checkbox"/> Case Manager      | <input type="checkbox"/> Attorney                     | <input type="checkbox"/> Employer                         | <input type="checkbox"/> All other Related Persons |

- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
- 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 of the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge and hereby give my AudigyCertified™ practice permission to treat my concerns.

**I have read and understand all the above information.**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(A copy of this signature is as valid as the original) mm dd yyyy