



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

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

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

---



---

## Insurance Information

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

### **Please read carefully and sign below.**

- I give permission to Professional Speech & Hearing Specialists 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 health care 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 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, completed the above answers, and certify this information is true and correct to the best of my knowledge, and I hereby give my hearing care provider permission to treat my concerns.

### **Please read carefully and sign below.**

---

Patient Signature (A copy of this signature is as valid as the original)

Date

---

Signature of Parent or Guardian

Date