Welcome to Tinnitus Specialists of New Mexico (TSNM)

I understand that TSNM does not accept insurance and any charges billed by this clinic are my responsibility. If requested, TSNM will provide an invoice for me to bill my insurance on my own. I understand all necessary paperwork must be received by TSNM 48 hours prior to my scheduled appointment. I understand that appointment cancellations/rescheduling must be done at least 48 hours prior to my appointment. If the patient is under 18 years of age, the undersigned is responsible for any balance due.

A Notice of Privacy Practices is available for any patient who would like one. The notice describes our policies relating to the privacy of health related information. The notice also describes your rights with respect to your health information. I have been informed that a Notice has been made available to me.

By signing below I agree to both statements listed above.

_____ _____ _____

Print Name Signature Date

COMPLETE THIS SECTION ONLY IF YOU RECEIVED A HEARING TEST FROM SOMEWHERE OTHER THAN WORTH HEARING CENTER

Title: ◯ **Mr.** ◯ **Mrs.** ◯ **Ms.** ◯ **Miss** ◯ **Dr.** ◯ **Sr.** ◯ **Rev.** **Gender:** ◯ **Male** ◯ **Female**

Date of Birth: _____

Legal Name: Last_____, **First**_____, **Middle Initial**_____

Address: _____

City: _____ **State**:_____ **Zip code**:_____ **e-mail address** _____

Home Phone:_____ **Work Phone**: _____

Cell Phone:_____ **Other Phone** :_____

How did you hear about us?

◯ Website ◯ Advertisement
◯ Family physician (name) _____ ◯ Ear physician (name) _____
◯ Patient (name) _____ ◯ Other (please describe)_____

Primary Care Physician: _____
Emergency Contact: (or parent/guardian if patient is a child)

Name _____
Relationship: _____ Phone:_____
Address: _____
City: _____ State: _____ Zip code: _____