Stacey L. Woods, Au.D., CCC-A
Mandee L. Riddell, Au.D., CCC-A
Charles A. Perine, Au.D., CCC-A
Eileen M. Gordon, Au.D., CCC-A
Lindsay M. Flaherty, Au.D., CCC-A
Carla A. Kurtz, M.A., CCC-A
Alex Markle Au.D., CCC-A

Registration Form *(Please Print Clearly)*

Date ______________________

Patient Information

Name ____
Last First Middle Initial

Home Phone ____________________________ Cell Phone ____________________________

Street Address ____

City ______________________ State ______________________ Zip __________

Email Address ____

Date of Birth ______________ Gender ☐ Male ☐ Female Social Security Number ______________

Marital Status __________ Employer ______________ Work Phone ______________

Primary Care Physician ____________________________ Who Referred You to Us? ______________

Responsible Party Information

Name ____
Last First Middle Initial

Relationship to Patient ____

Street Address ____

Social Security Number ______________ Date of Birth __________ Employer ______________

Work Phone ____________________________ Home Phone ____________________________

According to the Notice of Privacy Practices, we may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Please note the name and relationship to the patient of those you give us permission to disclose medical information:

Legal Last Name	First Name	Relationship to Patient

Acknowledgement of Receipt of the Notice of Privacy Practices

I acknowledge that I have reviewed and/or received a copy of the Notice of Privacy Practices. This notice describes the use and disclosure of my protected health information and rights I have regarding my protected health information.

Print Name ____________________________ Signature ____________________________

Date ______________ Relationship if patient is under age 18 ____________________________

By signing below, I authorize CHAC to send me educational and/or marketing information on the products and services offered by CHAC. No financial obligation or payment is expected for these services. I understand that I may revoke this authorization in writing at any time.

Signature ____ Date ______________