(((The Hearing Center)))

New Patient Information

Name: _____DATE: _____

Address: _____

Date of Birth: _____ Home Phone: _____ Cell Phone: _____

Work Phone: _____ Marital Status (circle One) S M D W

RESPONSIBLE FOR BILLING (circle one) Self/parent/other

Name: _____ DOB: _____

Address: _____

Work Information:

Employer: _____

Address: _____

Insurance Coverage (insurance card must be present at the time of visit)

Primary Insurance:

Insurance Company: _____ Insurance ID: _____

Group #_____

Cardholder Name: _____ DOB: _____

Secondary Insurance:

Insurance Company: _____ Insurance ID: _____

Group # _____

Cardholder Name: _____ DOB: _____

Name of Physician: _____ Report Requested: (Y N)

All professional services rendered are charged to the patient, necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize the release of any medical information necessary to my insurance company for the processing f my claims.

DATE: _____ SIGNATURE: _____

(((The Hearing Center)))
Pediatric Case History

Name of patient:_____Date:_____

Address:_____ Date of

Birth:_____ Age:_____ Gender:_____

Patient's pediatrician and phone: _____

Patient's School and phone:_____Grade:_____

Reason for visit:_____

Suspicion of hearing loss? Why? _____

_____Previous Hearing Test

Date and Results: _____

_____

Hearing Aid Make/Model/Date of Fitting (if applicable) _____

_____

<u>Medical History (Circle all that apply)</u>

Complications during Pregnancy ☐ Complications during Delivery ☐

Failed Newborn Hearing Screen ☐ Speech/Language Delay ☐

Other Developmental Delays ☐ Enrolled in Early Intervention ☐ History

of hearing loss in family ☐ Ear infections/Ventilation Tubes ☐

Other Illnesses/hospitalizations ☐

Please explain:

_____

_____

_____

_____

(((The Hearing Center)))

OFFICE POLICIES

1. All patients will be asked to produce a valid photo ID at the time of their appointment. If you have had an appointment within the last six months, this requirement will be waived. If not, the staff will verify your current information and if appropriate, require you to complete a new patient registration form.
2. All payments and CO-payments are due before services are rendered. We cannot bill you for co-payments. We accept check, cash, credit cards (Visa, Mastercard, Discover, Amex). The patient/guarantor is responsible for all payments regardless of insurance coverage.
3. If your health insurance requires a referral, it is your responsibility to obtain a referral from your primary care physician prior to your appointment. If you do not have a referral at the time of your appointment, you are responsible for payment as your insurance company may not pay for your visit without a referral.
4. Patients with outstanding account balances will be notified 10 days prior to submission to collection. Accounts that go into collection will be subject to a 35% collection charge. Accounts with balances that exceed 60 days will be subject to a late fee of $10.00, which will then be added to the account balance every 30 days thereafter.
5. There is a $35 charge for returned checks
6. It is your responsibility to notify our office of any name changes or changes in address, phone numbers, or insurance coverage. We need this information to bill your insurance company, and in the event that we have outdated information, any accumulated account balances will be your responsibility.
7. Patients under the age of 18 must be accompanied by an adult.

Patient Signature: _____

Guardian Signature: _____

Printed Name: _____

Privacy Practices Acknowledgement

Patient Name:_____

Please fill out the following information sign and date below.

The Hearing Center **may** leave private health information, on an answering machine or voice mail, regarding the above named patient.

Please list phone numbers where we may contact you or leave messages:

HOME:_____

WORK:_____

CELL:_____

EMAIL:_____

List people or family members with whom we may leave private health information.

_____relationship_____

_____relationship_____

_____relationship_____

I have been provided an opportunity to review the Notice of Privacy Practices.

Signed_____ Date_____