Patient Information Form

Mr. **Mrs.** **Ms.** **Dr.** (Circle One) Today's Date ____________

Full Name ______________________________ DOB ____________
First MI Last mm dd yyyy

Mailing Address ______________________________
Street City State ZIP

Secondary Address ______________________________
Street City State ZIP

Home Phone # ____________ Cell Phone # ____________

Work Phone # ____________ Other # ____________

Email Address ______________________________

Marital Status ○ Married ○ Single ○ Widowed *Spouse's DOB ____________
(*If covered by spouse's insurance)

Patient Employer ____________ Occupation ____________
(If retired, prior occupation)

Insurance (Only if hearing aids are covered): ______________________________
(If so, please furnish copies of all insurance cards, including Medicare)

Personal Physician ____________ Address ____________
(If not sure of address, please designate with city/medical group physician practices out of)

Whom have you seen regarding your hearing? ______________________________

When (approximately)? ____________ Do you currently wear aid(s)? ____________

How did you hear about us? ______________________________

Additional Background Information

Purpose of your visit ______________________________

When did you first notice you had a hearing problem? ______________________________

What do you think caused your hearing loss? ______________________________

Is there a family history of hearing loss? ______________________________

Was your hearing loss gradual or sudden? ______________________________

Does your hearing seem to fluctuate? ______________________________

Do you have noise or ringing in your ears? ____________ Dizzy spells? ____________ Nausea? ____________

If yes to any of the above, please describe ______________________________

Recent earaches?________ Ear infections?________ Ear discharge?________ Ear surgery; if so, when? ________

Have you ever been around loud noises, either in your job or hobbies? ______________________________

Optional: Medical Information Release

I, the undersigned, do hereby authorize Better Hearing Center to furnish any medical information to:

____
(Family member's name, physician, etc.)

Date ____________ X ______________________________
(Family member's name, physician, etc.) (Signature)

Office Policy

Thank you for choosing Better Hearing Center as your hearing health care provider. The following is a list of our office policies. All prospective patients must read, sign, and date this form at the bottom of the page before being seen. You may request a copy of this policy for your records.

1. Fees for professional services are due at the time of service.
2. If you are being fit with traditional hearing aids, a deposit of 50% may be required at the time of the order, and the balance is due upon receipt of the hearing aid(s) unless special arrangements are made. We offer a 45-day trial/return policy on all new traditional hearing aids.
3. If you are traveling or for other reasons choose to obtain service from a provider outside Better Hearing Center for hearing aids purchased from Better Hearing Center, please understand that you are responsible for any charges incurred.
4. Medicare only covers a limited number of medically necessary professional services when referred by a physician. Medicare does not cover the cost of hearing aids. If we provide services that may be billed to Medicare, we will bill for those services.
5. HMO/Other Insurance: If you belong to an HMO or believe you have hearing aid coverage through your health insurance, you must contact them directly to determine your particular benefits. Have them confirm that you may be seen at our office, and find out about co-pays and deductibles. Get this in writing if possible. All required authorizations must be mailed or faxed to our office. ***Payment for hearing devices and/or services is due and payable on the date received, whether or not you have insurance coverage.*** As a courtesy, we will submit the claim to your insurance to initiate the reimbursement process, but, if necessary, you are responsible for any follow-up required to obtain personal reimbursement from them.
6. Appointments: Please help us to serve you better by making an appointment for any service. If you must cancel, please give us 24 hours' notice.

Authorization to release insurance information and assignment of benefits:

I hereby authorize Better Hearing Center to furnish any information to my insurance carrier concerning this illness or condition, and I hereby assign to them all payments for medical services rendered and all major medical benefits. I understand that I am financially responsible for any unpaid balance due.

WE ACCEPT VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, AND CARECREDIT

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

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read, and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand this organization is not required to agree to my requested restrictions, but if it does agree, then it is bound to abide by such restrictions.

Print Patient Name ______________________________

X ______________________________ Date ______________________________
(Patient Signature)

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this
Notice of Privacy Practice Acknowledgement but was unable to do so as documented below.

Date ________________ Initials ________________ Reason ______________________________