Patient Demographic Form

Patient Information

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Please circle all that apply: Male/Female Employed/Retired/Other Married/Single/Other

Companion/Relative Name: _____ Phone: _____

Primary Doctor: _____ Phone: _____

Referring Physician: _____ Phone: _____

Referring Physician Address: _____

Would you like your results sent to your family doctor? **Y / N** (circle one)

How did you hear about us? Referred By: Doctor: _____ (Name) Friend: _____ (Name)

Newspaper: _____ (Name of Paper) Mailing: _____ (Type) Other: _____ (YellowPages, Internet, Signage, Outreach)

Insurance Information - Please provide Insurance card(s) with this completed form

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Insured's ID#: _____

Policy Group ID#: _____ Social Security #: _____

Insurance Plan Name/Program: _____ Policy Holders Relationship: _____ (self, spouse, child, other)

Do you have Medicare Coverage? **Y / N** (circle one)

Policy Holder's Employer Name: _____ Phone: _____

Secondary Insurance Information

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Insured's ID#: _____

Policy Group ID#: _____ Social Security #: _____

Insurance Plan Name/Program: _____ Policy Holders Relationship: _____ (self, spouse, child, other)

Do you have Medicare Coverage? **Y / N** (circle one)

Policy Holder's Employer Name: _____ Phone: _____

Financial Agreement:

We participate in many different insurance plans. We will file your insurance claims for the companies with whom we are contracted. You will be responsible for any co-payments or deductibles at the time services are rendered. For some insurance we accept assignment of benefits but in all cases we require that the guarantor, the person who is financially responsible, is personally liable for all balances not covered by insurance. It is our responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance companies. You will be responsible for co-payment, deductibles, out-of-network amounts or any portion your insurance company indicates is your responsibility. Payment for co-pays are expected at the time of service. If this fee is not covered by insurance it will be your responsibility. We allow your insurance company 45 days to pay your claim. If we do not receive payment in 45 days, you will be given a bill at that time. For our HMO/PPO patients, if we are contracted with your HMO/PPO, you will not receive a bill until we have heard from your insurance company.

Assignment of Insurance Benefits:

I hereby authorize direct payment to Hearing Health of any insurance or health benefits otherwise payable to or on behalf of the patient for examination, treatment or devices delivered to me by Hearing Health, at the rate not to exceed Hearing Health's usual charges. I understand that verification of insurance coverage obtained over the phone or online is estimated and does not guarantee payment and that insurance coverage is a relationship between the patient and his or her insurance company(s). I agree to accept financial responsibility for any charges for goods and services rendered to the patient that are not paid by insurance or health benefit plan pursuant to this assignment of benefits. I have been informed that Medicare does not provide payment for hearing aids, other assistive listening devices or fitting examinations.

Release of Information:

I hereby authorize Hearing Health to release any medical information about the patient necessary to determine liability for payment and to process any claim for examination, treatment or devices received by the patient. I also authorize Hearing Health to release the medical records of the patient to the patient's referring physician or family physician indicated on the first page of this form.

Financial Responsibility Agreement by Other than Patient's Legal Representative:

I agree to accept financial responsibility for the good and services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Benefit, and Release of Information provisions above.

HIPAA Acknowledgement:

By signing below, I acknowledge that I received a copy of Hearing Health's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

I have read and agree to the terms above:

Signature of Patient or Legal Representative — Date

Signature of Insurance Policy Holder — Date

Relationship to Patient — Witness (Hearing Health)