NORTHGATE HEARING SERVICES

We listen so you can hear

Welcome to our office. Please complete the following information and sign where indicated.

Date_____

Patient Name_____ Birthdate_____ Age_____

Address _____
Apt. # City State zip code

Secondary Address _____
Apt. # City State zip code

Home phone number (_____)_____Cell phone number (_____)_____

E mail _____

Employer _____ Occupation _____
(If retired, prior occupation)

Spouse/Significant Other's Name _____

Primary Care Physician _____ Phone # _____

How did you hear about us?

Website	Newspaper ad	Insurance	Yellow Pages	Employer
Mail	Sponsored event	Magazine ad	TV	Internet

Referred by Friend _____

Referred by Physician _____

Other _____

PERSON RESPONSIBLE FOR BILL (if other than patient) _____

PERSON TO CONTACT IN CASE OF EMERGENCY (different from patient)

Name _____ Relationship_____ Phone number _____

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INSURANCE INFORMATION

Insurance Provider: _____

Medicare will cover hearing testing if your physician has ordered such testing for a diagnostic medical evaluation or to determine the appropriate medical o surgical treatment of a hearing deficit or related medical problem. Medicare **will not** cover hearing testing for routine hearing evaluations to check your hearin status and adjust your hearing aids.

- Insurance is a contract between you and your insurance company. It is your responsibility to know the requirements and stipulation of your policy. Some services may not be covered benefits under your insurance plan. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.
- I authorize my insurance benefits to be paid directly to Northgate Hearing Services (NHS).

PROTECTED HEALTH INFORMATION

- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
- I authorize NHS to disclose my medical/protected health information for the purpose of my hearing healthcare and treatment, billing and/or insurance related information. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out hearing care and treatment. NHS is not required to agree to the restrictions that I request, however, if NHS agrees to a restriction that I request, the restriction is binding on NHS. In addition to using and disclosing medical information to any person or entity other than required by HIPAA regulations, I consent to NHS releasing my medical information to those detailed below.

Print Name	Relationship	Phone number
Print Name	Relationship	Phone number

- I consent to NHS to send newsletters, direct mailers, brochures, or any other correspondence for any and all marketing purposes related to audiological products/services to me. NHS will only disclose protected health information to companies that are in compliance with federal privacy regulations by signing a Business Associate Agreement. I understand that the practice may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described. I understand that this marketing authorization is in effect until a revocation is received by NHS.
- I have read all the information on this sheet and hereby give Northgate Hearing Services permission to treat my concerns.

I have read and understand all of the above information.

_____

Patient/Guardian Signature Date