PATIENT INFORMATION

Name (Legal Name) _____ Preferred Name _____

Date of Birth _____ Gender _____ Marital Status ☐Single ☐Married ☐Divorced ☐Widowed

Spouse Name _____ Is your spouse a current patient here? ☐ Yes ☐ No

Address _____ City _____ State _____ Zip Code _____

Phone - Home _____ Cell _____ Work _____

Preferred Phone - ☐ Home ☐ Cell ☐ Work

Please indicate if we have your permission to leave or send messages regarding your medical care:

☐ Yes, I authorize Mile High Hearing to leave or send messages containing Personal Health Information on the following:

Phone - ☐ Home ☐ Cell ☐ Work *and/or* ☐ Email _____

☐ No, I do not authorize Mile High Hearing to leave or send messages containing Personal Health Information.

Occupation _____ Employer _____

Primary Care Physician _____ Referring Physician _____

How did you hear about our practice? _____

Auto Injury ☐ Yes ☐No Work Comp ☐ Yes ☐No Claim #_____ Date of Accident _____

INSURANCE INFORMATION

Does the patient have health insurance? ☐ Yes ☐No

***If yes, please complete the remaining "Insurance Information" section.**

PRIMARY INSURANCE

Insurance Company _____

ID # _____

Policy or Group # _____

Plan or Program Name _____

POLICYHOLDER INFORMATION

Name _____

Complete below if patient is not the policyholder

Relationship to Patient _____

Date of Birth _____ Gender _____

Phone _____

Address _____

Employer _____

SECONDARY INSURANCE

Insurance Company _____

ID # _____

Policy or Group # _____

Plan or Program Name _____

POLICYHOLDER INFORMATION

Name _____

Complete below if patient is not the policyholder

Relationship to Patient _____

Date of Birth _____ Gender _____

Phone _____

Address _____

Employer _____

EMERGENCY CONTACTS

Name _____ Relationship to Patient _____ Phone _____

Name _____ Relationship to Patient _____ Phone _____

RELEASE OF INFORMATION

I authorize the release of any of my Personal Health Information to the person(s) listed below and give my permission to leave a telephone message directly with the person(s) and telephone numbers listed below.

Name _____ Relationship to Patient _____ Phone _____

Name _____ Relationship to Patient _____ Phone _____

Name _____ Relationship to Patient _____ Phone _____

I understand I have the right to revoke this authorization at any time. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I certify that this request has been made voluntarily. Unless otherwise revoked, this authorization will not have an expiration date.

Please carefully read the following items.

Insurance Authorization: I hereby authorize payment directly to Mile High Hearing and authorize the release of any medical information necessary to process insurance claims and for utilization review and quality assurance.

Payment Agreement: I understand that I am financially responsible for all charges not covered or billed to any insurance or third party payer and/or not paid to Mile High Hearing. Should the account be turned over to collections, I will pay all costs of collection including, but not limited to, agency fees, attorney fees and court costs.

Notice of Privacy Practices: I have been given a copy of the Mile High Hearing Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Treatment Consent: I voluntarily agree to the tests, procedures, and/or treatments the audiologist has deemed necessary and that are administered to or performed on me under the direction of the audiologist.

No Show/Cancellation Policy: I understand that if I am unable to make my appointment, I need to call and reschedule 24 hours prior to my appointment. I understand that if I arrive late for my appointment, I may be asked to reschedule. If I do not show for my appointment and do not call the office to cancel my appointment 24 hours in advance, it will be considered a no show and I may be charged a $30.00 no show fee.

NEWSLETTER

Yes, I would like to receive email newsletters from Mile High Hearing.

Email _____

I certify that the information on this form is correct to the best of my knowledge and I agree to the terms listed above.

_____ _____

Signature of Patient / Legal Guardian / Power of Attorney **Date**