Hearing Health Services
Hearing & Balance Center

New Patient Intake Form

PATIENT INFORMATION

Date: _____

Legal Name: _____ Suffix: _____ ☐ Female ☐ Male

Preferred Name: _____ Birth Date: (MM/DD/YYYY) _____ Age: _____

Marital Status: (Please check one) ☐ Single ☐ Married ☐ Widowed ☐ Partnered

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

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

Home Phone: _____ Cellphone: _____

Email: _____ Consent to Participate in Electronic Health Correspondence: ☐

Spouse Name: _____ Spouse Phone: _____

Employment Status: (Please check one) ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Student

Place of Employment: _____ Occupation: _____

Work Telephone: _____ May we contact you at work? _____

Emergency Contact Person: _____ Relation to Patient: _____

Address: _____ Contact Phone: _____

Primary Care Physician: _____ Clinic: _____

Referred By: _____ ☐ Friend ☐ Newspaper ☐ Direct Mail Piece

☐ Other: _____

List all persons permitted access to your medical records and notifications:
(This includes to whom we may disclose information, as well as who can represent you, schedule your appointments, accompany you on visits, pick up/drop off devices, etc.)

_____

_____

Persons NOT Permitted to Access Your Health Records: _____

Reason for Visit: _____

_____

GUARANTOR INFORMATION

(i.e., Person Responsible for the Bill, If Different From Patient)

Name: _____ Relation to Patient: _____

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

PAYMENT INFORMATION

☐ Private Pay

☐ Primary Insurance: _____ Subscriber Name: _____

Identification #: _____ Group #: _____ Subscriber DOB: _____

☐ Secondary Insurance: _____ Subscriber Name: _____

Identification #: _____ Group #: _____ Subscriber DOB: _____

PERMISSION TO BILL INSURANCE

I request that payment of authorized Medicare and/or any other insurance company that I furnish to this provider be made either to me on my behalf or to Hearing Health Services for any services furnished to me by this establishment. I authorize any holder of medical information about me to be released as needed to the Health Care Financing Administration and its agents for the determination of benefits payable for related services. This authorization may be revoked at any time if a written request is provided and all prior services have been paid in full. I assume responsibility for all denied or non-covered services.

Patient Balances

If a payment is not made on time, we may need to use outside services to help recover the remaining balance. This can include things like attorney fees or collection agency charges. If that happens, these charges will be added to your account. We'll always do our best to work with you before it gets to that point.

_____ _____

Patient Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices for Hearing Health Services, LLC. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of services or the performance of office health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information.

_____

Name of Patient or Personal Representative

_____

Signature of Patient or Personal Representative

_____ _____

Description of Personal Representative's Authority Date

The Privacy Rule portion of the HIPAA regulations requires our practice to submit a copy of the Privacy Notice to each patient, both existing and new. If the patient refuses to sign this notice, this practice is not obligated to treat the patient.