Patient Information

Patient's Name_____

Address_____City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone _____

Email Address_____ Date of Birth_____ Sex: Female___ Male____

Marital Status: Married___ Single___ Other___ Student Status: Full Time___ Part Time___ None___

Employment Status: Full Time___ Part Time___ Retired _____None___

How did you hear about us?_____

Primary Physician_____

Primary Insurance Information (If the patient is also the insured, enter 'SAME' for name and address)

Insured's Name_____

Address_____City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone _____

Patient Relation to Insured: Self___ Spouse___ Child___ Other___

Insured Date of Birth_____ Insured Sex: Female_____ Male_____

Insured Employment Status: Full Time_____ Part Time_____ Retired_____ None_____

Insured Employer_____

Insurance Company Name_____

Subscriber ID Number_____ Group Number_____

Secondary Insurance Information (If the patient is also the insured, enter 'SAME' for name and address)

Insured's Name_____

Address_____City_____ State_____ Zip_____

Patient Relation to Insured: Self___ Spouse___ Child___ Other___

Insured Date of Birth_____ Insured Sex: Female_____ Male_____

Insured Employment Status: Full Time_____ Part Time_____ Retired_____ None_____

Insured Employer_____

Insurance Company Name_____

Subscriber ID Number_____ Group Number_____

Signature _____ Date _____

Cindy Bazell Wilson, Licensed Audiologist 25211 Coolidge Hwy., Oak Park, MI 48237
Phone: 248 544-0560 – Fax 248 544-7480 – hearbetter1@yahoo.com – www.innovativehearingservices.com

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of, your Notice of Privacy Practices. This privacy notice contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions.
However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I wish to be contacted in the following matter (circle all that apply)

Leave a message with detailed information	YES or NO
Leave a message with call back number only	YES or NO
Mail office updates (e.g. newsletter)	YES or NO

Signature _____ Date: _____

Relationship to Patient: _____

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ASSIGNMENT OF INSURANCE BENEFITS

Patients with insurance, please read and sign below:

Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims or accept responsibility for negotiating claims with your insurance company. As a courtesy, we will be happy to help you determine the coverage you have available.

My benefits were discussed in advance and I decided that the service and treatment we agreed on is the best course of care. I understand that most insurances cover a basic hearing aid. Reimbursement to the provider will be based on my insurance allowed amount for the basic hearing aid and the provider may charge me for the difference between the payment and the billed charge.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans to Innovative Hearing Services, Inc. A photocopy of my insurance card and a copy of my driver's license are to be considered as valid as an original.

I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Innovative Hearing Services to release all information necessary to secure the payment. If insurance pays only a portion of the bill or fails to make payment to Innovative Hearing Services, Inc. within 90 days, I will be responsible for payment of the balance in full at that time. It is my responsibility to provide Innovative Hearing Services, Inc. with a medical clearance from an Ear, Nose & Throat (ENT) doctor prior my appointment.

_____

Patient's Name Signature Date

MEDICARE PATIENTS:

I request payment of authorized Medicare benefits to be made to Innovative Hearing Services, Inc. for any services rendered. I authorize any holder of personal medical information to be released by the Health Care Financing Administration and its agents. I also authorize the release of any information needed to determine these benefits or related services to pay the claim. If there are other insurance carriers, my signature authorizes release of information. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible for only the deductible, coinsurance and the non-covered services. Coinsurance and the deductible are based upon the charge determined by the Medicare carrier. Medicare only covers testing. If I would like Innovative Hearing Services to bill Medicare for my hearing test a prescription is required from my physician prior to my appointment. This can also be faxed by my doctor's office to Innovative Hearing Services at 248 544-7480. Medicare does not cover hearing aids.

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Patient's Name Signature Date

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RELEASE/OBTAIN OF INFORMATION

Patient's Name_____ Birthdate _____

PERMISSION TO RELEASE RECORDS

We provide you with important information about your hearing. We feel it is important for your physician to have this information for your medical records. By signing this form you are providing us with permission to send a copy to your physician. This release will be in effect until we receive written notice from you requesting that we no longer forward this information.

Patient / Guardian Signature _____ Date _____

Physician or Referring Agency _____

PERMISION TO OBTAIN RECORDS

In order to provide you with the best service possible, we may need to contact your previous audiologist or hearing aid dispenser, your physician or hearing aid manufacturer for information regarding your hearing, hearing aids, warranty, etc. This release will be in effect until we receive written notice from you requesting that we no longer obtain this information from this source.

Patient / Guardian Signature _____ Date _____

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