PATIENT INFORMATION

Name (Legal Name) _____ Preferred Name _____ Date of Birth _____

Gender _____ Marital Status ☐Single ☐Married ☐Widowed Spouse Name_____

Address _____ City _____ State _____ Zip Code _____

Phone - Home _____ Cell _____ Work _____

Preferred Phone - ☐ Home ☐ Cell ☐ Work

E-mail _____ (used for newsletters and communications from Mile High Hearing)

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 _____

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

How did you hear about our practice? _____

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 _____

TIERTERARY INSURANCE Insurance Company _____

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.

Insurance Participation: While our office participates in most health plans, it is your responsibility to verify that Mile High Hearing participates with your health plan prior to your appointment.

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.

E-mail: Your email will be used for communications such as appointment confirmation, appointment reminders, and education office newsletters.

No Show/Cancellation Policy: When we schedule an appointment, we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule your appointment, please contact our office as soon as possible, no later than 24 hours prior to your scheduled 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.

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**