Hearing Health Services

The care you need and quality you deserve.

20 NW Birch Street
Coupeville, WA 98239

Patient Information:

Date _____

Legal Name: Mr./Mrs./Ms./Dr. _____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: _____

Snowbird Address: _____ City: _____State: ____ Zip: _____

Home Phone: _____ Cellular Phone: _____

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:
(Who may we disclose information to, represent you, schedule your appointments, accompany you into visits, pick up/drop off devices, etc.)

_____

_____

Persons NOT Permitted to access your Health Records: _____

Reason for Visit: _____

_____

Guarantor Information: (Person Responsible for the Bill – if different from patient)

Name: _____ Relationship to Patient: _____

Address _____ City: _____Zip:_____

Payment Information:

☐ Private Pay

☐ Primary Insurance: _____Subscriber's Name: _____

Identification #: _____ Group # _____ Subscriber's DOB: _____

☐ Secondary Insurance: _____ Subscriber's Name: _____

Identification #: _____ Group #: _____ Subscriber's 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 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 written request is provided and all prior services have been paid for in full. I assume responsibility for all denied or non-covered services.

_____ _____

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 in 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.