HEARING & BALANCE CENTERS OF WEST TENNESSEE
The Jackson Hearing Center

Name: _____ **Date:** _____

INSURANCE INFORMATION

PLEASE PROVIDE INSURANCE CARD(s) FOR COPYING AND SIGN BELOW:

I agree that I am personally responsible for all charges incurred on behalf of the above named patient. I also understand that these charges are due and payable by me on the same day services are rendered. I also agree, if, for any reason, it is necessary to refer this account to any agency for collection, I will pay all cost-incurred in the collection of this account including attorney fees.

Signature: _____ Date: _____

Medicare Beneficiaries Only: I request that payment of authorized Medicare Benefits be made either to me or on my behalf to The Jackson Hearing Center for any present or future services furnished by the supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature: _____ Date: _____

Witness: _____ or _____
Nearest
Relative/Guardian

HIPPA - Notice of Privacy Practices for Protected Health Information

I have been given a copy of this notice and have had a chance to ask questions about how my personal health Information will be used. I know that I can contact the State Department of Human Rights Commission at 615-741-5825 if I have further concerns.

Signature: _____ Date: _____