Whittier Hearing Center - New Patient Information Form

Complete BOTH SIDES of this form. Copies of your insurance cards are required so please bring them with you to your appointment. This is necessary to determine if you have any benefits for hearing aids or professional services. If you need assistance filling out the form, just ask.

Name:_____ Age:_____ Birth Date:_____

Mr. Mrs. Ms. Miss Dr. Rev. Sister Father — month/day/year

Address:_____

Street — City — Zip

Preferred Phone: (_____)_____ Home__ Cell__ Work__

2nd phone at which you can be reached: (____)_____Home__ Cell__ Work__

Email Address: _____

May we use your email address to contact you? __Yes __No

How do you prefer to be contacted for appointments? __ Phone __E-Mail __Text

Occupation: _____

If retired what was your primary line of work for most of your life?

Referred By: __Physician __Web Site __YELP __A Friend __Other

Please list name of physician or friend who referred you _____

Your Family Physician: _____

Name — Address & phone number if you know it.

Who came with you today?_____

Name — Relationship

Nearest relative not living with you?_____

Name — Relationship — Phone

INSURANCE INFORMATION: Please indicate ALL of your insurance providers below. We will make a copy for our records and return the originals to you.

__Medicare __Medi-Cal __VR __AARP __PERSCare __Secure Horizons __Blue Cross

__Blue Shield __Cigna __SCAN __United Health Care __PacificCare __HealthNet __Caremore

__Kaiser __Blue Shield 65+ __Aetna Other_____

Is your insurance through yourself or someone else? __Self __ Spouse __Parent

Name of spouse/parent_____ Their date of birth_____

If you are here for hearing aids would you like us to check for benefits? __Yes __No

Print Name:_____ Date of Birth:_____

Review each of the items below. Initial next to each item indicating that you have read and understand each item. Please sign and date the bottom of the page. For items that do not apply to you, just do not initial them. If you have questions please ask one of our staff. (Whittier Hearing Center is noted below as WHCI.)

FINANCIAL RESPONSIBILITY

_____ I understand that I am financially responsible for all services and products provided to me by Whittier Hearing Center, Inc. All co-pays and deductibles are due at the time of service. Whittier Hearing Center bills as a courtesy and I am responsible for all fees and charges if the insurance company denies payment.

ASSIGNMENT OF BENEFITS

_____ I assign all audiological and hearing aid benefits to WHCI and give permission for WHCI to bill directly and to collect for all covered services. I agree to a release of all medical information necessary to process the claim. This assignment shall remain in effect until revoked in writing.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ I acknowledge that I received a copy of WHCI Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. I understand that a copy of the current Notice will be posted in the reception area and our website. You can request a copy at any time.

ACKNOWLEDGEMENT OF RECEIPT OF AUTHORIZATION FOR MARKETING

_____ I acknowledge that I received a copy of WHCI Authorization and Release for the Use and Disclosure of PHI for Marketing. This document allows you to choose to receive marketing materials from us or to opt out. It also tells you we never share your PHI with anyone for marketing reasons.

EXPLANATION OF MEDICARE BENEFITS AND COVERAGE

_____ I understand that Medicare does not pay anything toward the purchase of hearing aids, including hearing tests done for the purpose of purchasing or fitting hearing aids. Medicare does pay for audiological testing when it is ordered by a physician for the purpose of diagnosing a medical problem We bill Medicare for diagnostic hearing tests ordered by your physician and to get denials if you have hearing aid benefits from another provider. We *do not* bill Medicare for tests done to fit or adjust hearing aids. You are responsible for any charges for those non-diagnostic tests.

WAIVER OF MEDICAL EVALUATION

If you are here for a hearing aid consultation and have not seen a physician about your hearing loss in the last 6 months please read and initial your choice in this section. Doing this in no way obligates you to purchase a hearing aid.

The FDA has determined that your best health interests may be served by having a medical evaluation, preferably by an ENT, before purchasing a hearing aid.

_____ I want to waive my right and proceed with the hearing aid consultation. I am not under any obligation to order or purchase a hearing aid.

_____ I wish to see an ENT before discussing hearing aids.

Patient or Guardian's Signature:_____ Date:_____