WEST COAST HEARING CLINIC
You should HEAR what you're missing!

Last Name _____ First Name _____ Initial _____

Nickname _____ Birth Date _____ /_____ /_____ Age _____ Gender ☐ M ☐ F

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ SS# _____ DL# _____

Status: ☐ Single ☐ Married ☐ Partner ☐ Widowed ☐ Separated ☐ Divorced

Employment: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired

Patient/Parent's Employer _____ Occupation _____

Student: ☐ Full-time Student ☐ Part-time Student ☐ Not a Student

Language: ☐ English ☐ Spanish ☐ Other _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other _____

Primary Care Physician _____ Referring Physician _____

Responsible Party

Person Responsible for Account _____ Relationship to Patient _____

Birth Date _____ /_____ /_____ SS# _____ DL# _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Employer _____ Occupation _____

Insurance Information

Please give your insurance information to our front office staff, so we can make a copy for our records.

Primary Insurance

Subscriber Name _____ Relationship to Patient _____ Birthdate _____ /_____ /_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Subscriber Employer _____ Occupation _____

Insurance Company _____ SS# _____

Contract # _____ Group # _____ Subscriber # _____

Is Patient Covered by Additional Insurance? ☐ YES ☐ NO

Additional Insurance

Subscriber Name _____ Relationship to Patient _____ Birthdate _____ /_____ /_____

Address _____ City _____ State _____

Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Subscriber Employer _____ Occupation _____

Insurance Company _____ SS# _____

Contract # _____ Group # _____ Subscriber # _____

Worker Compensation Information

Worker Compensation Insurance Carrier _____ Employer _____

Claim Number _____ SS# _____

Financial Agreement

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered. Copayments are required at the time medical services are rendered.

If the patient is a minor, the parent signing this agreement is ultimately responsible for payment.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. You must provide all insurance policy information or changes to our office. As a courtesy, we will submit claims to your insurance carrier. You may need to contact your insurance carrier regarding the slow or non-payment of your claim.

You are responsible for knowing what services your insurance will cover. We suggest you check directly with your insurance company to understand your specific plan prior to diagnostic testing and treatment. You will need to notify our office should your plan require prior authorization.

Please read carefully and sign below

I acknowledge that I have received and reviewed the Health Insurance Portability and Accountability Act (HIPAA) policy at this office.

I authorize the release of any information concerning my (or my child's) healthcare, advice, treatment (verbal and written) contained in my medical record and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, relayed health care providers, assignees and/or beneficiaries and all other related people for the purpose of evaluating and administering claim for insurance benefits. I also hereby authorize payment directly to the medical provider. Information without patient identifiers may be used for quality purposes.

I authorize the use and release of my protected health information for marketing related hearing care products or services. I understand that the practice may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or services is being described. I understand that this marketing authorization is in effect until a revocation is received by the practice.

Medicare Patients Only

I request that payment of authorized Medicare benefits and, if applicable, Medicap benefits be made to the medical provider for the services provided. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medicap insurer, and their agents any information needed to determine these benefits or benefits for related services.

I have read all the information on this sheet and certify this information is true and correct to the best of my knowledge and hereby give West Coast Hearing Clinic permission to treat my concerns.

I have read and understand all the above information.

Signature of Patient _____ Date _____

Signature of Guardian (if minor) _____ Date _____

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