Last Name: ___________________________ **First Name:** _____________________ **Date of Birth:** ___________

Address: ____ **Apt #:** ___________________________________

City: ______________________________________ **State:** ____________________ **Zip:** ____________________

Phone Number: _______________________ **Sex:** M F

Cell Number: ______________________________ **Ok to text?** YES NO

Email Address: _____________________________ **Ok to Email?** YES NO **Marital Status:** S M D W SEP

Primary Insurance Company: ____________________________ **Policy Number:** __________________

Policy Holder Name: ____________________________ **Policy Holder Date of Birth:** ___________

Relationship to Insured: _______________________

Secondary Insurance Company: _________________________ **Policy Number:** ___________________

Policy Holder Name: _______________________________ **Policy Holder Date of Birth:** ___________

Relationship to Insured: _______________________

Would you like a copy of the hearing test results sent to your primary care physician? YES NO
***Primary Care Physician (Required*):** _______________________ **City or Zip:** _____________ **Phone #**______________
Referring Physician: ______________________ **City or Zip:** _____________________ **Phone #** ______________

☐ I authorize the release of my audiological results to the referring physician and/or primary care physician.
PLEASE SIGN: Patients signature required for the release of medical information.

PATIENT SIGNATURE: ____ **DATE:** ________________________

AUTHORIZATION FOR RELEASE OF INFORMATION BY EAR WORKS AUDIOLOGY, P.C.
I hereby authorize and direct the above named clinical practice, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such treatment. Upon my request for release of my medical records, I hereby authorize Ear Works Audiology, P.C. to furnish all records and results to the parties I specify.

ASSIGNMENT OF BENEFITS
I hereby assign, transfer and set over to the above named clinical practice sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my medical costs of the care and treatment rendered to myself or my dependent in said practice. I understand I am responsible for any services not covered by my insurance. I accept responsibility for payment of my account.

PATIENT SIGNATURE: ____ **DATE:** _______________________

Last Name: ____________________________ **First Name:** ______________________ **Date of Birth:** ____________

How did you hear about our practice? ____
What prompted you to come in today? ____
What would you like to get out of today's appointment? ____
Have you ever had your hearing tested before? YES NO
If yes, when? _________________________________
How long have you experienced hearing loss? ____
Where do you notice the most difficulty hearing? ____
Do other people say you have a loss? YES NO
If yes, who? ____
Have you ever worn hearing aids? YES NO
If yes, for how long have you been wearing them? ___________________

Do you experience dizziness? YES NO
Do you experience any fluctuations in your hearing? RIGHT LEFT NO
Do you have a family history of hearing loss? YES NO
Do you have a history of ear infections? YES NO
Do you experience feelings of fullness and/or pain in your ears? RIGHT LEFT NO
Do you have any tinnitus (ringing, buzzing, hissing) in your ears? RIGHT LEFT NO
Do you have a history of exposure to loud noises? YES NO
Have you ever had surgery in your ears? YES NO

Please circle any conditions that you currently have or have had in the past:
Heart Disease High Blood Pressure Low Blood Pressure Vision Problems Memory Loss
Head Injury Migraine Headaches Diabetes Dementia/Alzheimer's

I have been advised that Medicare requires health care providers to maintain a complete listing of all current medications, vitamins, and supplements that I am currently using in my patient file. I must include dosage, frequency, and route of use. Check one:

☐ I am currently taking the following medications

☐ At this time I do not wish to provide Ear Works Audiology with this information.

☐ I have provided an attachment with my medication information.

Name of medication	Dosage	frequency/route
______________________________	_____________	______________________
______________________________	_____________	______________________
______________________________	_____________	______________________
______________________________	_____________	______________________
______________________________	_____________	______________________

PATIENT SIGNATURE: ____ **DATE:** ______________________

As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the US Department of Health and Human Services office of Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices, or in accordance with your wishes as stated below.

This waiver authorizes Ear Works Audiology, P.C. to send/give my medical information as noted:

Leave a voicemail recording including my Personal Health Information on my home/cell phone: ☐ Yes ☐ No

Leave a voicemail recording including my Personal Health Information on my business phone: ☐ Yes ☐ No

Use of electronic communications (i.e. email, fax, electronic messaging) to transmit prescription, Treatment, disorder related information, lab or other results: ☐ Yes ☐ No

Permit the individual stated below (Personal Representative) to receive prescriptions and/or test results: ☐ Yes ☐ No

Speak to a family member of my choosing (Personal Representative) regarding my Personal Health Information: ☐ Yes ☐ No

Name of Personal Representative: ____

On this date ______________________________ I received and reviewed Ear Works Audiology, P.C.'s Notice of Privacy Practices, which describes how my medical information may be used and disclosed and explains how I can get access to this information.

I had an opportunity to raise questions ***regarding this HIPAA policy*** and all of my questions have been answered. ☐ Yes ☐ No

The authorizations made above will remain effective until such time as I notify Ear Works Audiology, P.C. in writing, be certified mail, of requested changes.

____ ___________________________

Patient Signature **Date**

____ ___________________________

Patient Phone Number **Date of Birth**

FINANCIAL POLICY

Thank you for choosing Ear Works Audiology, P.C. as your hearing healthcare provider. The following is a statement of our financial policy which we require that you read and sign prior to any service.
Any patients must complete our information and insurance form before being seen.
FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS WE ARE PARTICIPATING WITH YOUR INSURANCE CARRIER.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AMERICAN EXPRESS and DISCOVER.
****There will be a $30.00 charge for any returned checks.**

Patients with participating Insurance coverage:
All co-pays, deductibles, referrals and/or pre-certification/authorization numbers are expected at the time of service. Please be aware that even though we may be a participating provider in your insurance plan, all services may not be covered. Therefore, verification of coverage does not mean payment in full. If your insurance company does claim that they provide 100% coverage of hearing aids, then you may be limited as to the level of technology that you may obtain.

Patients with non-participating Insurance coverage:
Where we do not participate with your insurance carrier or your insurance coverage has been denied, you are ultimately responsible for payment in full. Your insurance company is a contract between you and your insurance company. We are not a party to that contract. If you have out-of-network benefits, then you may request that we submit the billing to your insurance company. We then may choose to accept assignment of benefits upon verification of your insurance coverage. Please be aware that in cases where we accept what the insurance will pay there may still be co-pays and/or deductibles that you will be responsible to pay. If your insurance company has not paid your account in full within 45 days, you will be held responsible for the payment. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the terms of the policy.

Usual and Customary Rates:
Our practice is committed to providing the best service for our patients and we charge what usual and customary for our area. Where we are a participating provider and payment is provided for a hearing aid purchase, and then we are only able to provide you with the level of technology that is considered reasonable and customary by your insurance plan (which is usually entry level digital). Where we are a non-participating provider, you are responsible for payment regardless of your insurance company's determination of usual and customary rates.

Minor Patients:
A legal guardian must accompany all minor patients. The legal guardian is responsible for full payment.

Patients Signature: ____ **Date:** ___________________

Legal Guardian's Signature (if applicable) : ____