Hearing Care Specialists, Inc.

Please Print clearly

DATE:

Name:____Birthdate:__________________ Age:__________

Primary Address:____

Street City State Zip

Secondary Address:____

Street City State Zip

Home Phone: (______)____________________________ Cell Phone: (______)____________________________

Other Phone: (______)____________________________ Other Phone: (_____)____________________________

EMAIL address:____

For periodic emails, i.e. newsletter, product updates, etc. We will not share your address with anyone

Sex: Male Female Marital Status: Single Married Widowed Separated Divorced

Spouses Name:____________________________ Parents/Guardians Name:________________________________

Employer:_______________________________________ Occupation:_____________________________________

Primary Care Physician:_________________________________ Phone: (______)____________________________

Emergency Contact:_____________________________________ Phone: (______)____________________________

Relationship to patient:____

How did you hear of *Hearing Care Specialists? (check all that apply)*

_____ Physician name:__________________________ _____ Friend name:______________________________

_____ Newspaper Ad/Insert name:__________________ _____Yellow Pages (DEX Yellow Book)

_____ Hearing Care Specialists Website _____ Online Search _____ Other _____________________________

This area must be completed carefully and entirely for proper submission of your insurance claim. Failure to do so could result in non-payment of claims

INSURANCE INFORMATION: (Please present your insurance card/s)

Primary Insurance:____

Address:____________________________________ Phone: (_____)____________________________

ID#:_______________________________________ Group#:________________________________

Insured:______________________________________ Insured Birthdate:________________________

Insureds address (if different than pt):____

Phone: (_____)_____________________________ Employer:______________________________

Relationship to insured:____

Is there other insurance? YES NO

SIGNATURE AUTHORIZATION

Hearing Care Specialists, Inc. is a privately owned company; all billing will be conducted through the corporation. I authorize direct payment of any medical benefit for services performed be made to Hearing Care Specialists, Inc. I understand that I am ultimately responsible for the balance on my account for any professional services rendered and/or products purchased, and that co-payments are due at the time of service. I also understand that I will be billed on the current balance of my account regardless of the insurance claim status. I understand that accounts over 90 days old may be referred to a collection agency, at which time interest may be charged. Hearing Care Specialists, Inc., will be happy to assist me with filing my insurance claim, I also understand that I am financially responsible to Hearing Care Specialists, Inc. for charges not covered by my insurance plan. I understand that it is my responsibility to know the rules and regulations of my specific plan, as well as what coverage is included on my plan. It is my responsibility to contact my insurance carrier to determine if Hearing Care Specialists, Inc., is in my specific network.

I authorize Hearing Care Specialists, Inc., to release any information relating to the service/s obtained here and those services related to my treatment to other professionals and insurers as it may become necessary.

I understand that it is my responsibility to notify Hearing Care Specialists, Inc. if I am unable to keep my scheduled appointment. I also permit a copy of this authorization to be used in place of the original.

I have read and agreed to the above Signature Authorization section and comprehend that it will remain in effect until revoked by me in writing.

Signature:____ Date:______________________________

If this authorization is signed by a personal representative of the patient, please complete the following:

Name:______________________________________ Relationship to Patient:__________________________

Reason: Parent/Guardian of a minor Power of Attorney Other_____________________________________