PREMIER HEARING CENTER

PATIENT INTAKE FORM

Patient Information:

Name _____
First Middle initial Last

Address

Phone ( ) ( )
Day Cell Email

Gender ☐ Male ☐ Female **Date of Birth** (mm/dd/yy) **SS#**

Marital status ☐ Married ☐ Single ☐ Partner ☐ Widowed

Employment status ☐ Full time ☐ Part time ☐ Active Military ☐ Not employed ☐ Student ☐ Retired

Primary care physician **Referring physician**

Do you want results sent to your doctor? Primary care Y / N Referring Y / N

How did you hear about us? ☐ Mail ☐ Physician ☐ Internet ☐ Insurance ☐ Yellow pages ☐ Other ☐ Newspaper ☐ Friend ☐ Signage ☐ Premier Staff ☐ TV/Radio

If you selected Friend or Other, please name or describe: _____

Emergency contact Name Relationship Phone

Responsibility party Name Relationship Phone

If patient is under 18 years, please complete the section below:

Parent/Guardian Name Day phone: Cell phone:
Address:

Insurance Information

Please provide your Insurance card(s) with a completed copy of this form.

Primary policy

Policy holder's name		Insurance ID#	
Insurance Plan name		Insurance Policy Group #	

Secondary policy

Policy holder's name		Insurance ID#	
Insurance Plan name		Insurance Policy Group #	

If you are not the policy holder, please complete the section below

Policy holder's name Policy holder's date of birth

Policy holder's address

Policy holder's Phone Day: ( ) Cell: ( )

Policy holder's relationship ☐ Spouse ☐ Child ☐ Parent ☐ Partner ☐ Other:Describe

Additional Insurance Information – Please present any additional insurance cards

If this will be a claim that needs to be filed for Workers Compensation, please complete the following:			
Worker's Comp Company name		Claim number#	
Adjuster's name		Date of Injury	
Employer's name		Employer's phone	

Are you taking any medication? Please list in the boxes below (Required for insurance claims):			

Financial Agreement:

We participate in many different insurance plans. We will file your insurance claims for the companies with whom we are contracted. For most insurance we accept assignment of benefits but in all cases we require that the guarantor, the person who is financially responsible, is personally liable for all balances not covered by insurance. It is our responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance companies. You will be responsible for co-payment, deductibles, out-of-network amounts or any portion not reimbursed by your insurance plan. Payment for co-pays, co-insurance and any deductibles are expected at the time of service. If this fee is not covered by insurance it will be your responsibility. We allow your insurance company 45 days to pay your claim. If we do not receive payment in 45 days, you will be given a bill at that time. For our HMO/PPO patients, if we are contracted with your HMO/PPO, you will not receive a bill until we have heard from your insurance company.

Assignment of Insurance Benefits:

I hereby authorize direct payment to Premier Hearing of any insurance or health benefits otherwise payable to or on behalf of the patient for examination, treatment or devices delivered to me by Premier Hearing, at the rate not to exceed Premier Hearing's usual charges. I understand that verification of insurance coverage obtained over the phone or online is estimated and does not guarantee payment and that insurance coverage is a relationship between the patient and his or her insurance company(s). I agree to accept financial responsibility for any charges for goods and services rendered to the patient that are not paid by insurance or health benefit plan pursuant to this assignment of benefits. I have been informed that Medicare does not provide payment for hearing aids, other assistive listening devices or fitting examinations.

Release of Information:

I hereby authorize Premier Hearing to release any medical information about the patient necessary to determine liability for payment and to process any claim for examination, treatment or devices received by the patient. I also authorize Premier Hearing to release the medical records of the patient to the patient's referring physician or family physician indicated on the first page of this form.

Authorization to contact by mail, phone or email:

I hereby authorize Premier Hearing to contact me by mail, email or phone, to inform me of scheduled appointments, follow up or to keep me updated on the technological advances in the hearing field.

Financial Responsibility Agreement by Patient, Legal Representative or Other:

I agree to accept financial responsibility for the good and services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Benefit, and Release of Information provisions above.

I have read and agree to the terms.

Signature of Patient or Legal Representative _____ Date _____

Signature of Insurance Policy Holder _____ Date _____