Central Florida HEARING SERVICES

Informative. Compassionate. Personalized.

Patient Information Form

Last Name _____ Frist Name _____ MI _____ Date of Birth _____ Sex _____

Phone #(s) _____ Social Security # _____ SS # of Guardian (if minor) _____

Mailing Address (Street) _____ Other _____

City _____ State _____ Zip Code _____

Employed By _____ Work # _____

Whom may we contact in case of an emergency? _____ Phone # _____

Primary Ins. _____ Primary Ins. ID # _____

Name of Policy Holder _____ Policy Holders DOB _____

Secondary Ins. _____ Secondary Ins. ID # _____

Who is financially responsible for this visit? _____ INS Phone # _____ _____

We accept cash, check, and most major credit cards at the time of service rendered.

I authorize Central Florida Hearing Services, PLLC to release information requested with regard to processing my claims.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for balance on my account for any professional services rendered. I have read all the information on this Financial Agreement provided to me and clarify that it is correct. I will notify Central Florida Hearing Services, PLLC of any changes in my insurance or in the above information.

Financial Agreement

MEDICARE We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% coinsurance, which can be billed to a secondary insurance if you have one.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits to be made on my behalf to Central FL Hearing Services, PLLC for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluation and administering claims of benefits.

OUT OF NETWORK PLANS: You will be responsible for any balance your plan indicates is due on their Explanation of Benefits Form. We will adjust the charges to coincide with your plans UCR (Usual, Customary, and Reasonable) negotiated charges. All patients will be responsible for their coinsurance and deductibles.

Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Central FL Hearing Services, PLLC or any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to be released to my insurance company (or their agent), information concerning healthcare, advice, treatment, or supplies provided by me. This information will be used for the purpose of evaluation and administering claims of benefits.

Consent for Treatment

I voluntarily give my permission to the health care providers of Central Florida Hearing Services, PLLC and such assistants and other health care providers as they may deem necessary to provide services to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from, or until I withdraw my consent in writing.

I understand that Central Florida Hearing Services, PLLC services are provided by a range of hearing health professionals, some of whom may be in training. When applicable, all professionals-in-training are supervised by licensed staff.

If I have any questions regarding this consent form or about the services offered at Central Florida Hearing Services, PLLC, I will discuss them with the audiologist.

ACKNOWLEDGEMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have read the Notice of Privacy Practice, Financial Agreement, and Consent for Treatment. (Check One) □ YES □ NO

I wish to receive a COPY & Please Initial/Date to indicate a copy was given □ _____ Date _____

Notice of Privacy Practices Received (7 Pgs.)□ _____ Date _____ Financial Agreement Received

Signature _____ Date _____

Parent/Legal Guardian Signature _____ Date _____

FOR OFFICE USE ONLY:

Signed and Received by: _____ Date _____

Acknowledgement Refused: _____ Date _____

Efforts to Obtain & Reason for Refusal: