Hearing Wellness Center

Patient Registration Form

Today's Date:_____

Patient Name:_____ **Date of Birth:**_____

Street Address:_____ City:_____ State:_____ Zip:_____

Responsible Party:_____ Address (if different):_____

Snowbird Address:_____

Gender (circle one): Male Female Non-Binary/other **Email:**_____

Primary Phone:_____ Secondary Phone:_____

☐ OK to leave a voice message ☐ OK to text ☐ OK to leave a voice message ☐ OK to text

Which phone number is your preferred method of contact in the event of inclement weather or illness? Contact for rescheduling could be made during nonbusiness hours: 7am - 9am and/or 5pm - 8pm.

Please check all that apply:

☐ Primary
- ☐ Call ☐ Text

☐ Secondary
- ☐ Call ☐ Text

How did you hear about us?_____

Employment Status (circle one): Full-Time Part-Time Retired None

Employer:_____

Occupation:_____

Marital Status (circle one): Single Partnered Married Divorced Widowed

Name of spouse, if applicable:_____

Emergency Contact:_____Phone:_____

Relationship to Patient:_____

Referring Physician:_____Phone:_____

Primary Physician:_____Phone:_____

Insurance Information *We will make a copy of the front and back of your insurance cards for our records.*

Name of insured (if other than patient):_____Date of Birth:_____

Employer of Primary Insured:_____Relationship to Patient:_____

Would you like us to send a copy of your results and/or report to (circle ALL that apply):

Referring Physician Primary Physician Other:_____

Form continues on opposite side. Please flip over for HIPAA and marketing consent.

Hearing Wellness Center

HIPAA *Consent*

Patient Name:_____

I authorize any of the below mentioned people to have access to my health records; and/or discuss my audiology needs with regards to appointment times, inclement weather/illness cancellation and/or rescheduling, diagnosis, treatment plans, etc:

Name:	Phone:	Relationship to patient:

Patient Signature:_____ **Today's Date:**_____

☐ I certify this form is filled out accurately and to the best of my knowledge.

☐ I authorize Hearing Wellness Center to send me educational information on new products and services that may become available.

Signature:_____ **Date:**_____

Hearing Wellness Center

Patient Information & Authorization

This authorization is valid for one year from the date of signature.
In condition of the services and care to be furnished me by the Hearing Wellness Center:

CONSENT FOR GENERAL CARE:

I present myself for health care services at the Hearing Wellness Center to be provided by authorized employees of the clinic, in their professional judgement, be deemed necessary or beneficial. I realize that among those who attend patients are medical and other health care personnel in training who, unless requested otherwise, may be present during patient care as part of their education.

I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatments on my condition.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the Hearing Wellness Center to disclose information from my medical records (including transfer records) and/or business office records to whom the Hearing Wellness Center believes is responsible for the payment of my bill or is involved in my care and treatment. Should any portion of my records contain information regarding drug or alcohol abuse, consent is given to release such information necessary to obtain payment of my bill from insurance companies or other funding sources and names on the Requisition Records. I authorize the Hearing Wellness Center to obtain my medication history if available electronically through my insurance provider(s) and/or an electronic clearinghouse for insurance benefit prescription information. I may revoke this consent at any future date upon written notification to the Hearing Wellness Center: however, I understand the Hearing Wellness Center may release information in good faith from the date I sign this consent until the date I may choose to revoke it. I authorize use of my medical records and information for legitimate medical or scientific research purposes. Research procedures do not identify individuals by name or personal identifying characteristics.

MEDICARE/MEDICAID PATIENTS

I certify the information I gave in applying for payment under Title XVIII or XIX of the Social Security Act is correct. I request payment of authorized benefits on my behalf for any services furnished me by the Hearing Wellness Center to release to Medicare/ Medicaid and its agents any information needed to determine these benefits or related services. I understand I am responsible for the costs of non-covered services and for the deductible, co-insurance and co-payment charges allowed under federal regulations.

RECORD LOCATOR SERVICE

As authorized by Minnesota Statute 144.293 and the 2007 Wisconsin Act 108, Record Locator Service(s) allow authorized health care providers to quickly find the location of health information about you from participating providers.

OPT OUT

_____(initial) If I select this option, I am specifically requesting that my identification information and location of my health information from any Record Service(s) be excluded from access by any participating provider.

_____ _____

Signature of Patient or Authorized Representative | Date

Reasons patient did not sign:_____

CONSENT FOR USE OF HEIDI (HIPAA compliant, note taking tool providing real-time transcription)

_____ _____

Signature of Patient or Authorized Representative | Date

HEARING WELLNESS NOTICE OF PRIVACY PRACTICES

I acknowledge being offered the Hearing Wellness Center's Notice of Privacy Practices. _____ initials

FINANCIAL AGREEMENT

I agree to pay the Hearing Wellness Center for all services provided to me by the Hearing Wellness Center and others for whom the Hearing Wellness Center collects bills at the regular rates. This includes services which, for any reason, are not paid by insurance, government programs or other third party sources. I understand that any self-pay portion of my office bill is due upon notification. Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts to any servicers and any debt collectors of my accounts ("Affiliates"), by various means, including, without limitation an automatic telephone dialing system, text message, email or an artificial or prerecorded voice, through any medium I provide to you, including, without limitation any cellular phone, landline, email address, fax number, text number or any other form of contact information I directly or indirectly provide to you or your Affiliates ("Contact Information"). I further agree to pay reasonable attorney's fees and all costs of collection in the event my account is turned over to an attorney or collection agency.

I authorize payments be made directly to the Hearing Wellness Center of insurance, Medicare/Medicaid benefits or other funding sources I am entitled to as payment for services provided me. If assignment of insurance benefits is accepted by such physicians, I authorize insurance payments be made directly to those physicians.

I accept financial responsibility as outlined above:_____ _____

Signature of Guarantor | Date