MEDICAL HEARING ASSOCIATES, LTD.

Patient Information Form

First Name:_____ Middle Initial_____ Last Name_____

Address:_____City:_____State:_____Zip_____

Phone Number:_____ Cell Phone:_____

Date of Birth:_____ Gender: Male ☐ Female ☐

Email Address:_____

Employment: Retired ☐ Student ☐ Employed ☐ Not Employed ☐ Active Military ☐

If employed, List your Employer: _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Partner ☐ Widowed ☐ Legally Separated ☐

Spouse's Name (if pplicable):_____

Is spouse a patient with this practice: Yes ☐ No ☐

Snowbird Address (Address out of state)

Address:_____City:_____State:_____Zip:_____

Emergency Contact

Name:_____ Phone:_____

Relationship: Spouse ☐ Daughter ☐ Son ☐ Friend ☐ Other ☐

Responsible Party (Person who carries the insurance.)

Name:_____ Phone:_____

Relationship: Spouse ☐ Daughter ☐ Son ☐ Friend ☐ Other ☐

Primary Doctor

Doctor Name:_____ Clinic/Physician Facility:_____

People/Relation that we can release your medical or billing information to:

Name:_____ Phone:_____

Relationship: Spouse ☐ Daughter ☐ Son ☐ Friend ☐ Other ☐

Name:_____ Phone:_____

Relationship: Spouse ☐ Daughter ☐ Son ☐ Friend ☐ Other ☐

Office & Financial Policy
Please Read Carefully

Welcome to our Office

Our goal is to provide you excellent hearing care in a comfortable, personal and cost-effective manner. We hope that you will recognize that our financial policies have been developed to maintain this health care service for our patients and for the community, which means lower fees for you. You can help by paying for your care in a timely manner.

Payment at the time of service is expected

Payment for services is due in full at the time of service. Payments to Medical Hearing Associates, Ltd. may be made by cash, check, Visa, Mastercard, or Discover.

Medical Hearing Associates, Ltd. is happy to file your charges with your insurance carrier, but in order to bill your insurance company for your hearing care, it is extremely important that we obtain complete information about your primary and supplemental insurance coverage, including phone numbers, addresses, and a copy of your cards. Even though we bill your insurance company for you, we will still collect any office copayments from you at the time of service.

Participation vs. Non Participation (Insurance)

We may assist you, at your discretion, in verifying your insurance coverage in an effort to verify exactly what Audiology coverage is available on your policy. This can only be done on the day of your appointment if time permits. **You as the policy holder are primarily responsible to verify benefits**. We cannot guarantee payment of the benefits and subsequently you may be responsible for any coinsurance, deductibles, or fees for non-covered services that may result.

Referrals

If your insurance company requires a referral and /or preauthorization/pre-certification you are responsible for obtaining it. We most likely will not be able to obtain a referral on the date of service. (This will be at our discretion if time permits). An option at this point will be to reschedule the appointment or to pay at the time of service. We suggest you call your primary care doctor at least 24 hours in advance to confirm that your referral has been generated and faxed. **The most reliable method is to obtain it yourself**.

Medicare

We accept assignment from Medicare, so all payment from Medicare will be made directly to the doctor. We bill Medicare and your supplemental insurance directly. We are required by Federal Law to collect the amount Medicare approves, not just the 20% they do not pay.

By signing this contract you are agreeing to have Medicare authorize benefits to be made to Medical Hearing Associates, Ltd. You are also authorizing any holder of medical information about yourself to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or related services to pay the claim. If there are other insurance carriers, your signature authorizes releasing of information. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge and you are responsible for only the deductible, coinsurance and the non-covered services. Coinsurance and the deductible are based upon the charge determined by the Medicare carrier.

Insurance

We are happy to file charges with your insurance carrier, but you are responsible for contacting your insurance carrier to verify your benefits. The contract with your insurance is between you and your insurance carrier. You will be responsible for any portion that your insurance carrier assigns to you.

If we participate with your insurance carrier, only your co-pay is due at the time of service. Your insurance carrier will notify us of any deductibles or other charges for which you are responsible , and we will send you a bill for that amount. Unfortunately, some insurance carriers do not consider hearing healthcare to be a covered service, and you will be notified if they deny these charges. You will be responsible for any charges that your insurance carrier assigns to you.

If we do not participate with your insurance carrier, full payment is expected at the time of service, but we are happy to file a claim for you. Many carriers will reimburse you for your hearing healthcare; however, your bill is your responsibility whether your insurance company reimburses you or not.

By signing this form you are agreeing that your insurance policy is between you and your insurance company. We cannot guarantee payment of your claims or accept responsibility for negotiating claims with your insurance company. As a courtesy we will be happy to provide the claim forms necessary for billing for amplification (Hearing Aids).
You also hereby assign all medical benefits, to include major medical benefits to which you are entitled, private insurance and any other health plans to Medical Hearing Associates, Ltd. A photo copy of your insurance card(s) and a copy of your driver's license are to be considered as valid as an original.
You are financially responsible for all charges whether or not paid by the above insurance. You hereby authorize Medical Hearing Associates, Ltd. to release all information necessary to secure the payment. If insurance pays only a portion of the bill or fails to make payment for Medical Hearing Associates, Ltd within 90 days, you will be responsible for payment of balance in full at that time.

No Show and Cancelled Appointments
We will call the day before your appointment to confirm you attendance. If we don't reach you we will leave a message. Please give 24 hours notice if unable to keep an appointment. We reserve the right to charge a $25 fee for missed appointments or appointments that are cancelled without 24 hour notice.

Returned Checks
There is a fee (currently $50) for any checks returned by the bank.

Monthly Statement
If you have a balance on your account we will send you a monthly settlement. It will show the balance and any new charges to the account. Any unpaid balances older than 30 days may be subject to 1.5% interest fee per month.

Payments
Unless other arrangements are approved by us in writing, the balance on your account is due and paid when the statement is issued. If not paid by the end of the month it will be considered past due.

Past Due Accounts
If your account becomes past due, we will take the necessary steps to collect this debt. This may mean a collections agency. In the event of legal action you will be responsible for payment of any additional charges equal to the cost of collections, including agency fees, attorney fees and court costs incurred, as permitted by law governing this transaction. (Loss of discount and a charge of 1.5% interest on balance.)

Effective Date
Once you have signed this document, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Financial Agreement
- I agree to pay promptly all fees and charges for treatments provided to me and/or my family.
- I have read the policies above and understand them.
- I understand that I am financially responsible for all charges, whether or not they are covered by my insurance.
- I authorize Medical Hearing Associates, Ltd. to release to my insurance carrier any medical information needed to obtain payment for services.
- I understand that if I disagree with any charges, I will contact this office in writing within 30 days of the billing date.

Medical Hearing Associates, Ltd. will work to ensure that your hearing care is the finest available and it does not become a financial burden.

Signature: _____Date:_____