952-831-4222
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Audiology Concepts, LLC

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Today's Date: Appt Day:

PATIENT INFORMATION FORM Patient Type:

Last Name ______________________________ First Name ________________________________ MI ________

Address(Street) ____

City ____ State: _______ Zip___________________

Primary Phone: __________________ ☐ Cell ☐ Home Other Phone: ________________ ☐ Cell ☐ Home

Birth Date ____________ Sex _____ Email address:____

Family Contact:__________________________________Phone #_________________________ ☐ Cell ☐ Home
(Family Relation)

How did you hear of Audiology Concepts LLC? _____________________________________

Primary Care Physician: Clinc___________________________________

I request results to be sent to my Primary Care Physician Listed above: Yes _______ NO______

Primary Insurance Company _______________________________________ Insurance ID# ________________

Name of Policy Holder ____________________________________Policy holder's date of birth: _________________

Secondary Insurance Company_____ ________________________________Insurance ID# _________________

Who is financially responsible for this visit other than patient? ____

I authorize the release information requested with regard to processing my claims Yes _____ No_____

TO OUR PATIENTS: OUR FINANCIAL POLICY

Thank you for choosing us as your hearing healthcare provider. We are committed to your better hearing. Please understand that payment of your bill is considered part of your service. The following is a statement of our Financial Policy, which we require you read and sign prior to any service.

REGARDING HEARING AID PAYMENT

We will ask for your portion of payment at time of delivery of your hearing device(s).

REGARDING INSURANCE

We may accept assignment of insurance benefits. However, we do require payment of your portion of the bill (Co-Pay) to be paid at the time of service or at the delivery of hearing device(s). All accounts are payable within 30 days or receipt of your bill. It is important that patients with insurance realize that professional services are rendered to a person, not an insurance company. Hence, the insurance company is responsible to the patient and the patient is responsible to us. To avoid any misunderstanding you are advised to contact your insurance company to verify benefits for any services provided to you. We don't assume any liability for services not covered by your plan. Our business office will gladly assist you with verification of your benefits.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best service for our patients/clients and we charge what is usual and customary for our area. You are responsible for payment as determined by contracted rates, upgrade waivers, and/or any obligation to co-insurances or co-pays. Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy: ____Date:____________
(Signature of Patient or Responsible Party)

Please initial that the HIPPAA ***Notice of Privacy Practices*** was made available. ________ (initial)