Audiology Concepts Edina
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Patient Information Form

Today's Date: **Appointment Date:**

Patient Name: _____ **DOB:** _____ **Gender:** _____
Last *First* *Middle*

Address: _____ **City/State/Zip:** _____

Primary Phone: _____ **Type:** _____ **Secondary Phone:** _____ **Type:** _____

Email: _____

Family Contact: _____ **Relationship:** _____ **Phone:** _____

How did you hear about our clinic? _____

***Primary Care Physician:** _____ **Clinic:** _____

I request the results of my hearing test to be sent to my Primary Care Physician Listed above: ☐ **Yes** / ☐ **No**

Primary Insurance:	**Secondary Insurance:**
Policy Holder:	**Policy Holder:**
Policy Holder DOB:	**Policy Holder DOB:**
Policy #:	**Policy #:**
Group #:	**Group #:**
Who is financially responsible for this visit other than patient?	
I authorize the release of information requested with regard to processing my claims: ☐ **Yes** / ☐ **No**	

OUR FINANCIAL POLICY: Thank you for choosing us as your hearing health care provider. We are committed to your hearing health care needs. 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 to read and sign prior to any service.

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 of receipt of your bill. It is important for patients with insurance to understand 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 do not assume any liability for services not covered by your plan. Our Business office will gladly assist 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 coincidences or co-pays. Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy above: _____ **Date:** _____
(Signature of Patient or Responsible Party)

Please initial that the **HIPAA Notice Privacy Practices** was made available _____ **(initial)**