COVID-19 PATIENT SCREENING

We appreciate your cooperation and patience in helping to keep our patients and staff safe and healthy.

1. Have you been diagnosed with, or suspected to have COVID-19 in the past 30 days? **YES** **NO**

2. Have you been tested for COVID-19 in the past 30 days? **YES** **NO**
   If yes, when and where? ______________________________

3. Have you been in close contact to a person who is suspected or known to be positive in the past 30 days? **YES** **NO**

4. Have you traveled to a high-risk area in the past 30 days? **YES** **NO**
   If yes, when and where? ______________________________

5. In the past 48 hours have you had a fever of 99.5 or higher? **YES** **NO**

In the past **two weeks**, have you experienced the onset of the following:

Coughing	**YES**	**NO**
Sore Throat	**YES**	**NO**
Headache	**YES**	**NO**
Difficulty Breathing / Shortness of Breath	**YES**	**NO**
Pink Eye	**YES**	**NO**
Muscle Ache	**YES**	**NO**
Loss of Taste or Smell	**YES**	**NO**

Print Name: __________________________ Date: __________ Time: __________

Signature: _____________________________________

Screener Signature: ____________________ Date: __________ Time: __________

Patient Demographic Information

Last Name: ______________________ First Name: ______________________ MI: ______

Preferred Name: ______________________ Gender: __________

Date of Birth: ______________________ Age: __________ SSN: ______________________

Address: ____

City: ______________________ State: __________ Zip: __________

Home Phone: ______________________ Cell Phone: ______________________

Email Address: ____

(if under 18 years of age)

Mother's Name: ______________________ DOB: __________ SSN: __________

Father's Name: ______________________ DOB: __________ SSN: __________

Insurance Policy Holder's Information:

Last Name: ______________________ First Name: ______________________ MI: ______

Date of Birth: ______________________ Age: __________ SSN: ______________________

Relationship to the patient: ______________________

Employer: ______________________ Phone: ______________________

Address (if different than above): ______________________

City: ______________________ State: __________ Zip: __________

Home Phone: ______________________ Cell Phone: ______________________

Email Address: ____

Primary Care Physician: ______________________ Phone: ______________________

Referring Physician: ______________________ Phone: ______________________

Emergency Contact: ______________________ Relationship: ______________________

Phone: ______________________

How did you hear about us? ______________________

Financial Policy

- Our office does require the financially responsible party's social security number. If you do not wish to provide with this information, we can see the patient as a cash paying patient.
- At the time of your appointment, we will collect your co-pay, deductible, or co-insurance due for services provided.
- Non-covered insurances will be billed as a courtesy, but we request all services be paid in full on the date of service.
- All balances not paid by the insurance within 30 days will be transferred to patient responsibility and it will be your responsibility to contact your insurance.
- In case of default of payment of the account, interest will be charged to the account. The patient will be responsible for any legal interest on the account due, along with any collection costs and reasonable attorney fees incurred in collecting on the account.

I have read and understand Coastal Hearing Center's Financial Policy. I hereby authorize the insurance companies to pay directly to Coastal Hearing Center benefits due me, if any. I will pay all charges in excess of whatever sums may be paid. I authorize Coastal Hearing Center to release information to the insurance company for my claims to be paid. I understand that regardless of insurance coverage I am liable for all fees with deductible and cost shares being due on the date of service. I understand that in the case of default payment of this account, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney's fees incurred to effect collection of this account.

______________________________ ______________________

Patient Signature/Legal Guardian Date

No Show Policy

Auditory Evoked Potentials testing and Vestibular testing utilize valuable provider time and specialized equipment. Due to limited availability, it is critical that you maintain your appointment.

- If you fail to show for Auditory Evoked Potentials testing or Vestibular testing with Coastal Hearing Center, you will be subject to a $50.00 no show fee.
- Fees must be paid prior to rescheduling your appointment. These fees are not filed to the insurance and are your responsibility.

______________________________ ______________________

Patient Signature/Legal Guardian Date

Notice of Privacy Practices Receipt

I acknowledge that I was provided with the Notice of Privacy Practices for Coastal Hearing Center.

Authorization of Use or Disclosure of Protected Health Information

I, ____, hereby authorize the Audiologists and staff of Coastal Hearing Center to discuss personal information including appointment times, hearing aid information, test results, and billing/financial information with the following people:

Spouse: ____

Others Name: ____ Relationship: _________________________

Others Name: ____ Relationship: _________________________

I authorize the Audiologists and staff of Coastal Hearing Center to leave a message on my answering machine regarding upcoming appointments:

Yes _______ No _______

I authorize the Audiologists and staff of Coastal Hearing Center to contact me by email.

Yes _______ No _______

I understand that I may revoke this consent at any time by giving written notice to Coastal Hearing Center,

____ ____

Print Name of Patient/Representative Signature of Patient/Representative

____ ____

Date Signed Patient's Date of Birth