

# 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.

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Patient Signature/Legal Guardian

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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.

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Patient Signature/Legal Guardian

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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