KEY HEARING
4300 Talbot Road S. Suite 313 Renton WA 98055
425-277-9521 voice / 425-277-9522 fax

Welcome to Our Practice

Please fill in these forms to the best of your ability

Patient Name _____ Date of Birth _____/_____/_____ Age _____ Date _____

SSN# _____ Male ___ Female ___

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email Address _____

Work Phone _____ Alternate Phone _____

Primary Insurance Type: _____ ID: _____ Group: _____

Secondary Insurance Type: _____ ID: _____ Group: _____

Check Appropriate Employment Status: Full time ◻ Part time ◻ Self ◻ Retired ◻ Active Military ◻ Not Employed ◻

Patient's or Parent's Employer _____

Business Address _____ City_____ State_____ Zip_____

If patient is a student, name of school/college _____ City _____State _____

Please Check Appropriate Status: Minor ◻ Single ◻ Married ◻ Divorced ◻ Widowed ◻ Separated ◻

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Emergency Contact: _____ Relationship _____ Phone _____

Whom may we thank for referring you? _____ Receive Key Hearing newsletter (circle)? Y / N

Who is the referring physician? _____ Phone _____
(If different from above)

Who is your primary care physician? _____ Phone _____
(If you would like a copy of your results forwarded to your physician, please sign the release below)

The following must be signed so we can file your insurance claim for you:

I authorize the release of any medical and/or other information necessary to process my medical claim. I also request that payment of government benefits, either to myself or to the party who accepts assignment. Further, I authorize payment of medical benefits to be made directly to Key Hearing, PLLC/Leah Keylard, Au.D, CCC-A for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

_____ _____/_____/_____
Patient/Parent/Guardian Signature Date

Release of Medical Information

I, _____, hereby authorize Key Hearing to release any and all medical information in the course of my (or my child's) treatment to the primary care physician listed above.
I would also like to have this information forwarded to: _____

_____ _____/_____/_____
Patient/Parent/Guardian Signature Date

KEY HEARING
4300 Talbot Road S. Suite 313 Renton WA 98055
425-277-9521 voice / 425-277-9522 fax

Child Case History

Name_____ **Date**_____ Age_____

For what reason was this hearing test arranged?

_____

_____

_____

Is your Child one any medications? YES NO
If so, what and what for?

_____

_____

Has your child ever had a hearing test before? YES NO
If so, when, and where? _____

Do you have any concern about your child's hearing? YES NO

Does your child seem to hear better on some days than others? YES NO

Does anyone in your family have problems with hearing? YES NO

Were any of the following present after your child's birth or during the first two months?

__ Prematurity

__ Poor weight gain

__ Was in incubator

__ Did not pass hearing screening at birth

__ Difficulty breathing

__ Birth weight less than 5 lbs.

__ Appeared Yellow

__ Stayed in Hospital after mother went home

__ Infections at birth

__ Physical deformities

__ High fever

Does your child turn toward sound? __ Yes __ No

Has your child had ear infections? __ Yes __ No How Many? ___

KEY HEARING
4300 Talbot Road S. Suite 313 Renton WA 98055
425-277-9521 voice / 425-277-9522 fax

ASSIGNMENT RELEASE AND FINANCIAL AGREEMENT

It is very important for you to know your insurance deductible and has percentage of patient responsibility. You should review your insurance coverage or call your insurance company to review this information.

Problems related to your hearing and balance requires special attention. Diagnostic studies are performed through our office and these include VNG (ENG) and hearing tests. Additionally, we may perform procedures such as ear cleaning.

When you receive a statement from your insurance company describing a procedure/diagnostic study, please be advised that this refers to an "in office" procedure or diagnostic study performed during your **office visit.** Depending on your insurance plan, these charges may be applied to your deductible. (It is important for you to know your insurance deductible and percentage responsibility.)

Assignment Release and Financial Agreement

I hereby authorize treatment and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of services and I am financially responsible for non-covered services. I authorize the medical provider to release any information requested. I understand that my insurance may deny payment for any reason including, but not limited to the following services: services not provided by my primary care provider and services not authorized or covered by my insurance company. If the primary care physician does not provide the referral in cases where it's required, then the specialist visit may not be covered.

I acknowledge that failure to meet my financial obligations may result in referral of my account to a collection agency.

Patient Signature_____ Date_____

KEY HEARING
4300 Talbot Road S. Suite 313 Renton WA 98055
425-277-9521 voice / 425-277-9522 fax

NOTICE OF PRIVACY PRACTICES —ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Leah Keylard.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Patient or legally authorized individual signature | Date

_____ _____

Printed name if signed on behalf of the patient (parent, legal guardian, personal representative) | Relationship

This form will be retained in your medical record.

Last Update: 12/17/2013

KEY HEARING
4300 Talbot Road S. Suite 313 Renton WA 98055
425-277-9521 voice / 425-277-9522 fax

Notice of Non-Coverage/Patient Financial Responsibility

Patient Name: _____ Patient Number: _____

Name of Insurance Carrier: _____ Date of Notice: _____

Your insurance carrier will only pay for services that it determines to be medically reasonable and necessary under their applicable health insurance policies and guidelines or those which are covered benefit(s) within your current individual/family insurance policy.

Insurance carriers do not pay for every item or service requested by a patient or recommended by their audiologist. We have determined, in this case, that your insurance carrier will not pay for the following service(s) for the following reason(s):

Description of Services Likely to be Denied and/or Paid at Standard Rate	Reason for Non-Coverage or Denial	Estimated Patient Out of Pocket Cost
69210, 92717, E&M 99201-05; 99211-15	Item or service excluded or non-covered item or service, per medical policy or plan document	Office Visit-$150. Wax Removal-$150. Vemp $180.
	No specific procedure code exists to represent this item or service.	
	Item or service not medically necessary per medical policy or plan document.	
	Item or service selected for personal comfort or cosmetic purposes.	
	No coverage or reduced coverage when seeing an out of network provider.	

Beneficiary Agreement to Pay:

I have been notified by my audiologist that they believe that, in my case, my insurance carrier listed above is likely to deny payment for the services identified above. I understand that I have the right to decide whether to receive the service identified above. I have decided to receive the service. My insurance carrier will not be billed by this clinic for the item or service provided and I am accepting full financial responsibility for the costs associated with the items and services above. The financial responsibility is due on the date the service was provided or the item is dispensed, as allowed health insurance policies and guidelines.

Patient's Signature: _____ Date of Signature: _____

Beneficiary Refusal to Receive Item or Service at Own Expense:

I have been notified by my audiologist that it believes that, in my case, _____ (name of insurance carrier) is likely to deny payment for the item or service identified above, for the reasons stated. I understand that I have the right to decide whether to receive the item or service identified above. I have decided not to receive the item or service, since I am not willing to be personally responsible for payment.

Patient's Signature: _____ Date of Signature: _____