New Patient Paperwork 6-25



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 Phon	e	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 Retire	ed Active Military	Not Employed □
Patient's or Parent's Employer			
Business Address	City	Sta	te Zip
If patient is a student, name of school/college		City	State
Please Check Appropriate Status: Minor Sin	ngle Married Divorc	ed 🗆 Widowed 🗆 Se	eparated □
Spouse or Parent's Name	Employer	Work Pho	one
Emergency Contact:	Relationship	Phone	
Whom may we thank for referring you?		Receive Key Hearing	newsletter (circle)? Y/N
Who is the referring physician?(If different from above)		Phone	
Who is your primary care physician?(If you would like a copy of your results forwarded to your primary care physician?			
The following must be signed so we can file your in authorize the release of any medical and/or other information benefits, either to myself or to the party who accepts assignment PLLC/Leah Keylard, Au.D, CCC-A for services rendered. This are	on necessary to process my med nent. Further, I authorize paymen	t of medical benefits to be r	made directly to Key Hearing,
Patient/Parent/Guardian Signature	Date	_/	
Release of Medical Information			
I,, hereby authorize Kenchild's) treatment to the primary care physician listed at I would also like to have this information forwarded to	above.	d all medical information	in the course of my (or my
		_//	
Patient/Parent/Guardian Signature	Date	2	



Child Case History

Name	Date		Age	
For what reason was this hearing test arranged	?			
Is your Child one any medications? If so, what and what for?		YES	NO	
Has your child ever had a hearing test before? If so, when, and where?		YES	NO	
Do you have any concern about your child's he	earing?	YES	NO	
Does your child seem to hear better on some d	ays than others?	YES	NO	
Does anyone in your family have problems with	th hearing?	YES	NO	
Were any of the following present after your c	hild's birth or du	ring the	first two months?	
Prematurity	Appeared Ye	ellow		
Poor weight gain	Stayed in Ho	ospital at	fter mother went home	
Was in incubator	Infections at	birth		
Did not pass hearing screening at birth	Physical def	ormities		
Difficulty breathing	High fever			
Birth weight less than 5 lbs.				
Does your child turn toward sound? Yes	No			
Has your child had ear infections? Yes	sNo	How N	Many?	

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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 <u>I am financially responsible for non-covered services</u>. 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 r	result in referral of my account to a coll	ection agency.
Patient Signature	Date	

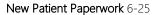
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We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or 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 Privac	y 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		



Notice of Non-Coverage/Patient Financial Responsibility

Patient Name:		Patient Number:	_
Name of Insurance Carrier:		Date of Notice:	
		dically reasonable and necessary under their applicabl t(s) within your current individual/family insurance poli	
		ent or recommended by their audiologist. We have owing 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.		
the services identified above. I under decided to receive the service. My in full financial responsibility for the co-	ist that they believe that, in my case, merstand that I have the right to decide volumence carrier will not be billed by thi	ny insurance carrier listed above is likely to deny payme whether to receive the service identified above. I have s clinic for the item or service provided and I am accep les above. The financial responsibility is due on the dat policies and guidelines.	oting
Patient's Signature:		Date of Signature:	
I have been notified by my aud carrier) is likely to deny payme I have the right to decide whet	nt for the item or service identific	y case, (name of insurance above, for the reasons stated. I understance identified above. I have decided not to receivensible for payment.	d that
Patient's Signature:		Date of Signature:	