1146 Francis Street • Longmont, Colorado 80501
303-651-1178 PHONE • **303-651-0488** FAX • **drudden@longmonthearing.com**
www.longmonthearing.com

D'Anne Rudden, Au.D., CCC-A
Doctor of Audiology • *Board Certified by the American Board of Audiology*

PATIENT REGISTRATION FORM

Please print and complete the following information using blue or black ink.

Choose one of the following Mr. Mrs. Ms. Dr. Today's Date ____________________

Patient Name ____ Male Female Adult Child
First MI Last

DOB _____/_____/_____ Age _________ Email Address ____
mm dd yyyy For use by this office only for warranty and other notifications.

Address (Mailing) ____

Physical Address (if different from mailing address) ____

Home # _________________________ Work # _________________________ Cell # ________________________

How would you like us to communicate with you? (select all that apply) Phone Email Text

Emergency Contact ____ Phone # ________________________

Primary Care Physician ____ Phone # ________________________

Referred by ____ Phone # ________________________

Would you like us to send a report to your Primary Care Physician Yes No

How did you hear about Longmont Hearing & Tinnitus Center? (check all that apply)

Referred by Physician Referred by a Patient/Friend Google or Internet Search
www.longmonthearing.com Found us in DEX, Yellow Book or White Pages Newspaper Advertisement
Received a Mailer Insurance Provider Referral Other ________________

Insurance: What is your **PRIMARY** insurance? ____ **SECONDARY** ____

Please provide the most current Primary and Secondary Insurance cards and a Photo ID to our Patient Care Coordinator so copies can be made for your patient record and for billing purposes.

Person Responsible for Payments ____

If patient is under the age of 18, a responsible party must complete the remainder of this section.

Name of Responsible Party ____
First MI Last

Address ____

Home # __________________________________ Work # ____ Cell # ______________________________________

HIPAA - Authorization for the Use or Disclosure of Protected Health Information (PHI)

I consent to the use or disclosure of my Protected Health Information (including audiograms) by Longmont Hearing & Tinnitus Center (Provider) for the purposes of diagnosing or providing hearing care and treatment of me.

I understand that diagnosis or treatment of me by Provider may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out hearing care and treatment. Provider is not required to agree to the restrictions that I may request. However, if Provider agrees to a restriction that I request, the restriction is binding on Provider.

I have the right to revoke this consent, in writing, at any time, except to the extent that Provider has taken action in reliance on this consent.

My "protected health information" ("PHI") means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to Provider's use or disclosure of my PHI for purposes of delivering relevant product and/or technology marketing communication to me. I acknowledge that Provider may receive financial remuneration from the manufacturer in connection with such communications.

____ ____ _______________
Signature of Patient or Personal Representative Print Name of Patient or Personal Representative Date

____
Description of Personal Representative's Authority

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Patient Name ____ Date ______________________

Medical & Audiological History

1. What medications are you currently taking? ____

____

____

2. Have you had any recent hospitalizations or surgeries? Yes No (If yes, please describe)

____

3. Have you ever had any surgeries to your ears? Yes No (If yes, please describe)

____

4. Do you clench your teeth? Yes No
5. Do you have any dizziness or balance problems? Yes No (If yes, please describe)

____

6. Do you have a history of ear disease? Yes No (If yes, please describe)

____

7. Is there a family history of hearing loss (under age 50)? Yes No
8. Do you have a history of loud noise exposure? Yes No (if yes, please describe)

____

About Your Hearing

Do you currently have any of the following symptoms? (If YES, please indicate which ear(s))

Deformity of the ear? Yes No Right Left
Sudden/Rapid hearing loss in the past 90 days? Yes No Right Left
Have you ever had wax removed from your ears? Yes No Right Left
Drainage from either ear in the past 90 days? Yes No Right Left
Do you have fullness or stuffiness in your ears? Yes No Right Left
If yes, please describe ____
Do you have difficulty hearing? Yes No Right Left
Do you have noise in your ears? Yes No Right Left
If yes, please describe ____
Do you have pain in your ears? Yes No Right Left
If yes, please describe ____
Do you use a particular ear on the telephone? Yes No Right Left
Have you worn hearing aids before? Yes No Right Left
If yes, how long? ______________________
If yes, are you having difficulties with them? Yes No (if yes, please describe)

____

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Social History

Do you use tobacco? Never Former Smoker Less than 1 pack per day 1 pack per day
1-2 packs per day 3 packs per day Oral Tobacco

Do you use alcohol? Never Rare Socially (1-2 drinks/week) Moderate Heavy

Do you use marijuana? Yes No If yes, how much and how often?______________________________
Delivery method (check all that apply): Ingested Smoked Other

Do you use recreational drugs? Yes No

Physical History

Please check, indicating yes, if you have any of the following conditions or symptoms

Constitutional
Recent weight gain
Recent weight loss
Other________________________

Neurologic
Stroke/CVA
Migrane
Other________________________

Cardiac
Congestive Heart Failure
Heart Attack
High Blood Pressure
Pacemaker
Heart Valve Disease
Other _______________________

Endocrine
Diabetes
Low thyroid
High thyroid
Other _______________________

Skin
Rash
Eczema
Other________________________

Infectious Disease
Hepatitis A/B/C
Tuberculosis
Measles
Mumps
Other________________________

Musculoskeletal
Arthritis
Other________________________

Psychological/Emotional
Depression
Anxiety
Bipolar disorder
Recent increase in stress
Other________________________

Cognitive Changes
Dementia
Alzheimer's
Other________________________

Blood/Immune System
Easy bleeding
Anemia
Cancer
Lupus
HIV/AIDS
Other________________________

Other
Liver disease
Visual impairment
Macular degeneration
Poor dexterity in hands
Change in taste/smell
Facial pain
Sinus pain/infections
Allergies
Other________________________

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Financial Policies

Please read, initial and sign, indicating your understanding of the following information. If you have any questions, please do not hesitate to ask. It is important that you understand these specific policies of Longmont Hearing & Tinnitus Center and that you understand how your insurance company will handle your claims.

__________ **It is your responsibility to provide this office with your current and correct insurance information.** You have been advised to obtain a referral from your primary physician for medical necessity. Failure to do so may result in the services being denied by your insurance provider. In the event that this should happen, you will be responsible for the incurred charges.

__________ **It is your responsibility to verify your coverage and adhere to the restrictions of your plan.** We participate with most major medical insurance companies. However, insurance companies frequently specify the time frame in which patients can be seen and the coverage widely varies group to payer. If appointments are made that are not covered by your insurance plan, you will be responsible for payment.

__________ **We do not always know if you have a deductible**, if your deductible has been met, or if you have a co-insurance policy. It is your responsibility to know this information. You are responsible for all charges that are not paid by your insurance company, including those applied to your deductible or co-insurance.

__________ **Discounts are offered on some medical services, but ONLY if you pay at the time of service**. If you have no insurance, or if you are receiving services that are not covered by your insurance plan, you may be eligible for a discount on some services. Payment must be made at the time of service for the discount to apply.

_________ **If you have a co-pay, you are expected to pay this when you check in for your visits.** Most insurance companies assign a co-payment to the patient and it is our responsibility to collect this at the time of service. We take payments in cash, checks, Visa, MasterCard, and Discover. Be prepared to pay your co-pay when you check in for each visit.

__________ **You may be charged fifty dollars ($50.00), if you fail to show up for your appointment or if you cancel your appointment with less than 24 hour notice.** Exceptions may be made for inclement weather. The correct number to call when canceling an appointment is **303-651-1178.**

I understand that Longmont Hearing & Tinnitus Center will need to use and disclose certain information as it relates to my treatment, payment for treatment, and healthcare options.

Longmont Hearing & Tinnitus Center will provide me with a copy of the HIPAA privacy information that describes how my medical information may be used and disclosed upon request.

____ ____________________

Signature of Patient/ Guardian Date Signed

Office Use only: Copy Provided: Yes Declined

Updated 12/15

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ASSIGNMENT OF INSURANCE BENEFITS – PLEASE READ, SIGN AND DATE

Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims or accept responsibility for negotiating claims with your insurance company. As a courtesy, we will be happy to help you determine the coverage you have available.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health claims to Longmont Hearing & Tinnitus Center. A photocopy of my insurance card(s) and a copy of my driver's license are to be considered as valid as an original.

I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Longmont Hearing & Tinnitus Center to release all information necessary to secure the payment. If insurance pays only a portion of the bill or fails to make payment to Longmont Hearing & Tinnitus Center within 90 days, I will be responsible for payment of the balance in full at that time.

______________________________________ __________________________

Signature of Patient/Responsible Party Date Signed

MEDICARE PATIENTS – PLEASE READ, SIGN AND DATE

I request payment of authorized Medicare benefits to be made to Longmont Hearing & Tinnitus Center for any services rendered. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents. You are authorized to provide any information needed to determine these benefits or related services to pay the claim. If there are other insurance carriers, my signature authorizes the release of information to these companies for the purposes of processing claims. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge and the assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible for only the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based on the charge determination by the Medicare carrier.

______________________________________ __________________________

Signature of Patient/Responsible Party Date Signed

IMPORTANT NOTICE TO ALL PATIENTS – PLEASE READ, SIGN AND DATE

It is impossible for us to know every insurance company plan and contract. Therefore, each patient is responsible for understanding his or her own policy. The insurance contract is between you and the insurance company and not Longmont Hearing & Tinnitus Center. It is important that you provide us with your current insurance information. Without a copy of the front and back of your insurance card, we are unable to file a claim on your behalf. If you do not give us the proper insurance information at the time of service, it will be your responsibility to file the claim privately.

__________________________ __________________________ ________________

Patient/ Responsible Party Name - PLEASE PRINT **Signature of Patient/Responsible Party** **Date Signed**