WESTERN COLORADO HEARING & BALANCE

Patient Name:

Appointment Date:

Appointment Time:

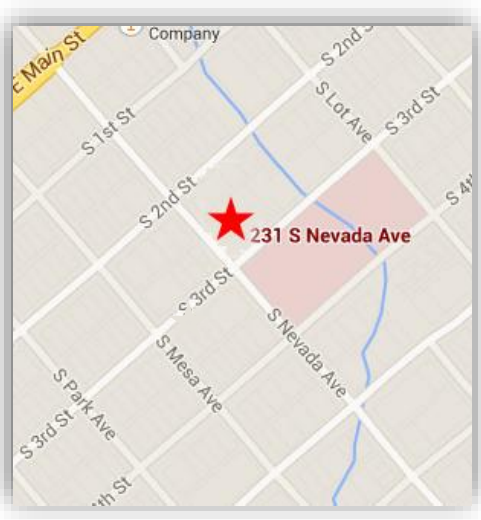
Clinic Location:

Please complete the attached paperwork and bring it with you to your appointment. Also remember to bring a complete medication list, your ID, and insurance information. If you have any questions, please call us at 970-549-4660. We look forward to seeing you soon.

Main Clinic Grand Junction

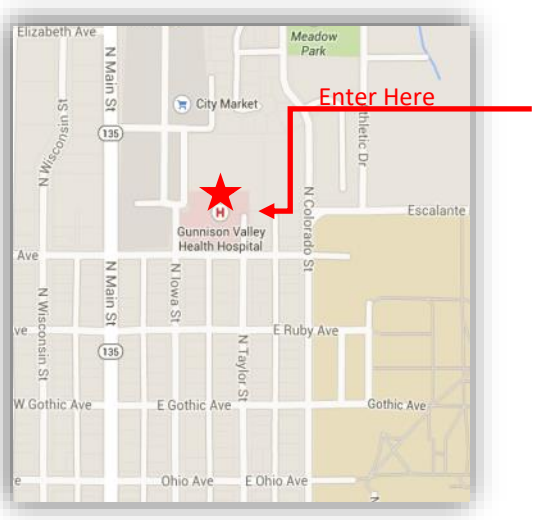
2139 North 12th Street
Unit 4 (North side parking lot)
Grand Junction, CO 81501

Specialty Clinic Montrose

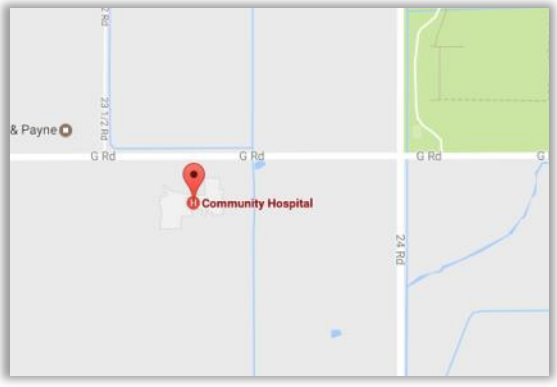


Montrose Clinic
231 S. Nevada Ave
Montrose, CO 81401

Specialty Clinic Gunnison



Gunnison Valley Hospital
711 N. Taylor Street
Gunnison, CO 81230



Community Hospital Location

Suite 100
2351 G Rd,
Grand Junction,
CO 81505

Enter through the Canyon View Medical Plaza Entrance

WESTERN COLORADO HEARING & BALANCE

PATIENT INFORMATION FORM

Patient Full Name: _____ Preferred Name: _____

DATE OF BIRTH _____ ☐M ☐F ☐O Marital Status: ☐ Single ☐Married ☐Divorced ☐Widowed

Physical Address: _____ City: _____ State:_____ Zip: _____

Mailing Address (if different than physical address): _____

Phone (Home): _____ Phone (Cell): _____ Phone (Work): _____
Can we leave you a voicemail with medical information at your (check all that apply): ☐HOME ☐CELL ☐WORK

Email Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Current Employment: ☐Full-Time ☐Part-Time ☐Retired ☐Self-Employed ☐Unemployed ☐Student ☐Child under 18
if patient is under 18 years of age, by signing below I acknowledge that I am a parent or guardian with legal rights to authorize healthcare services.

Occupation (if retired, list prior occupation/type of work performed): _____

Name of Family Physician: _____ Phone: _____
* Is it OK to send your referring physician a copy of your audio report? ☐YES ☐NO

*How did you hear about us? _____
*Is it OK to send you periodic practice updates and occasional news via email? ☐YES ☐NO

INSURANCE INFORMATION: To ensure your insurance benefits are maximized and protected, please provide the following information and provide your insurance card(s) and photo identification to the Front Desk. (We are required to make copies of your insurance cards.) If you do not have insurance or do not want your insurance billed, initial that you accept responsibility for all charges for services rendered due at time of service. If billed, I agree to pay within 30-days of receiving a statement. _____

PRIMARY Insurance Company: _____ Member ID#: _____
Is the Patient the Policyholder? ☐ YES ☐ NO IF NO – COMPLETE THE FOLLOWING INFORMATION:
Name of policy holder? _____ Policy Holder Birthdate: _____
Relationship to Patient: ☐ Spouse ☐ Parent ☐Other: _____

SECONDARY Insurance Company: _____ Member ID#: _____
Is the Patient the Policyholder? ☐ YES ☐ NO IF NO – COMPLETE THE FOLLOWING INFORMATION:
Name of policy holder? _____ Policy Holder Birthdate: _____
Relationship to Patient: ☐ Spouse ☐ Parent ☐Other: _____

AUTHORIZATIONS & POLICY ACKNOWLEDGEMENTS: My signature below indicates the following:

- ❑ **Insurance Authorization:**
  I authorize Western Colorado Hearing Clinic, PLLC to bill my health insurance company for services rendered at their facility and authorize the use of my signature on all insurance submissions. I agree to promptly pay (within 30-days) any amounts my insurance indicates are my responsibility.
- ❑ **Medical Records Release:**
  I authorize release of all information necessary to secure payment of benefits. I authorize any holder of medical information about me to release my records to Western Colorado Hearing Clinic any information needed to determine benefits payable and/or to coordinate my care for related services.
- ❑ **Financial Policy:**
  I understand that WCHC will bill my insurance for services rendered. I acknowledge the practice's Patient Payment Policy is on the following page (or reverse side).
- ❑ **Appointment No Show Policy**:
  I understand that there is a $50 no-show fee for 2 missed appointments.
- ❑ **HIPAA Privacy Practices Acknowledgement of Receipt**:
  I acknowledge that I have been given the opportunity to read the NOTICE OF PRIVACY PRACTICES, a copy of which is available in the waiting area. I understand a copy of this notice will be made available to me at my request.

PATIENT PAYMENT POLICY

I acknowledge it is my responsibility to know and be informed prior to my appointment if my provider is in/out of network with my insurance company. It is not the provider's responsibility to inform me if their office is out of network, unless I specifically ask for this information prior to the appointment. Western Colorado Hearing & Balance will not bring this up during my appointment, rather, it will be assumed that I have completed my own research in this regard.

IF MY APPOINMENT IS AT COMMUNITY HOSPITAL – GRAND VALLEY EAR, NOSE, & THROAT:
I acknowledge that Western Colorado Hearing & Balance is a ***completely separate entity*** than Grand Valley Ear, Nose, and Throat, & Facial Plastic Surgery. Additionally, I understand that I will receive an invoice from Western Colorado Hearing & Balance for my appointment with their providers. This invoice will be separate than the invoice I receive from the Community Hospital ENT office. I understand that, while the ENT office may be In-Network with my insurance company, Western Colorado Hearing & Balance providers may **NOT** be in network and that it is my responsibility to determine if WCHB is in- or out- of network with my insurance company prior to my appointment.
*Ask the front staff at Grand Valley Ear, Nose, & Throat for an insurance In-Network/Out-of-Network breakdown to determine if Western Colorado Hearing & Balance is contracted with your insurance company.

I acknowledge that payment for services rendered are due and payable at the time of service. Western Colorado Hearing & Balance will collect a co-pay/co-insurance in the amount of $45.00 at the time of service for all non-Medicare and non-Medicaid patients with an unmet deductible. This co-pay will apply towards the cost of services rendered.

By my signature below, I agree to pay this amount at the time of service or will be billed for this amount following the appointment.

For all patients: once insurance processes the claim submitted, I acknowledge that I will receive a statement of account via mail and agree to pay any amounts owed within 30- days. I acknowledge that I have read a copy of the Financial Policy below and a copy will be provided to me upon my request.

X _____ _____ _____
Signature (Parent/Guardian) Printed Name Date

OFFICE: Verified ID Matches Patient Name & Insurance Card: _____

	Jennifer Bebee, Au.D	Andrew Slawinski, Au.D.	Jo-an Mealler, MS
	In-Network	In-Network	In-Network
Medicare	X	X	X
Medicaid	X	X	X
Rocky Mtn	X		X
United HC	X	X	
UMR	X		

FINANCIAL POLICY

At Western Colorado Hearing & Balance, we're dedicated to providing the highest level of medically-oriented diagnostic and treatment services for hearing loss, tinnitus and balance disorders. It's our focus to **provide state of the art hearing aid technology** with **professional hearing care** at affordable prices you deserve and expect. **To accomplish this, we must be paid timely for services rendered.**

Insurance Billing:
- Whether or not we participate with your insurance company, we will bill your insurance for services rendered.
- Your insurance company will review the claim and determine the amount they will pay and/or the amount you are responsible for.
- Upon receipt of payment and/or notification from your insurance, any balance they determine is your responsibility will be billed to you via a statement from our office and is due within 30 days.

Insurance Disclaimer:
- When benefits are verified, most insurance companies will indicate you are eligible but include a disclaimer that states they will not guarantee payment even though you are eligible for benefits at the time of service.
- You will be responsible for payment of services rendered if your insurance company determines you are responsible for payment under the terms of your policy or denies payment of benefits for reasons unforeseen at the time they were rendered.

Non-Covered Services:
- Any non-covered services are payable directly by you.

Payment Due:
- It is your responsibility to provide us with a valid and current insurance card.
- If you do not have any insurance or did not produce a valid insurance card, or if you are receiving non-covered services, purchasing a hearing aid, or any other product, payment is due at the time of service.
- Hearing Aid purchases requires 5% down at time of order and the remainder due when fitted.
- Patient balances due after insurance processing are payable in full upon receipt of our statement.
- There is a $25 fee for returned checks.

Past-Due Accounts:
- Accounts unpaid over 90 days are considered past due.
- It is our policy that all past due accounts be sent three statements.
- If payment is not made, a single phone call will be made to try to make payment arrangements.
- If no resolution can be reached, the account will be sent to the collection service/agency, or attorney.
- In the event an account is turned over for collections, you may be responsible for the cost incurred to collect.