WESTERN COLORADO HEARING & BALANCE

PATIENT INFORMATION FORM

Patient Full Name: _____ Preferred Name: _____

DATE OF BIRTH _____ ☐M ☐F 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
* Is your referring physician different from your family physician? ☐YES ☐NO If Yes: _____

*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: _____

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WESTERN COLORADO HEARING & BALANCE

PATIENT HISTORY INFORMATION

Reason for Today's Visit / Symptoms: _____
When was your last hearing exam? _____

Do you have any of the following?

- An injury or surgery to your ears? ____Yes____No If yes, which ear? _____
  - What kind of injury or surgery? _____ When? _____
- Dizziness, vertigo, or balance problems? ____Yes____No
- Ringing, buzzing, humming, roaring, etc. in your ears? ____Yes____No If yes, which ear? _____
  - How bothersome is the above symptom? ____ Very ____ Somewhat ____ No longer noticed
- Worse hearing in one ear than the other? ____Yes____No If yes, which ear? _____
- Pressure or fullness in your ear(s)? ____Yes____No If yes, which ear? _____
- History of ear infections? ____Yes____No
- Wax removed by a doctor? ____Yes____No
- Ear pain? ____Yes____No If yes, which ear? _____
- Sudden or rapid hearing loss in the last 90 days? ____Yes____No If yes, which ear? _____
- Ear drainage? ____Yes____No
- Family history of hearing loss before age 50? ____Yes____No
- Diabetes? ____Yes____No
- History of Tobacco use? ____Yes____No Quit? _____
- History of loud noise exposure, even if decades ago? ____Yes____No
- Do you have a known hearing loss? ____Yes ____No If yes, how long? _____

What is your hearing aid experience? ____ Tried ____ Owned ____ None

- Year Tried/Purchased? _____ How often do you wear your hearing aids? ____ Full-time ____ Part-time
- **Describe your hearing aid experience:** _____

MEDICAL HISTORY AND MEDICATION LIST

Please check all that apply:

_____ Diabetes
_____ Current Tobacco Smoker
_____ Quit Smoking (When? _____)
_____ Compromised Immune System
_____ Received Chemotherapy within last 6 months
_____ Lupus
_____ Take Blood Thinners
_____ Dementia/Cognitive Decline
_____ Never Smoked
_____ Skin Irritations
_____ Radiation to the head or neck (ever)
_____ Rheumatoid Arthritis

Please list *any* other pertinent medical history information: _____
_____

MEDICATIONS

(If you brought a copy of your medications list, just give to the front office staff for copying).

NAME (GENERIC OR BRAND NAME)	DOSAGE	FREQUENCY	PURPOSE

Patient Name: _____ Date: _____ Date of Birth: _____

**Please NOTE:
Are you currently under any home health care benefit (i.e., but not limited to, physical therapy, occupational therapy, speech therapy), in a Skilled Nursing Facility, or under any other managed care arrangement where WCHB should be billing the facility, rather than your insurance directly?

☐ YES ☐ NO

If you indicated YES:
Medicare consolidated billing rules require all billing to go through the facility/care provider. Prior to your appointment, you must either sign an Advanced Beneficiary Notice (ABN) that indicates you understand you are responsible for any services rendered that the facility does not cover **(PLEASE ASK THE FRONT DESK STAFF FOR THIS FORM),** or you must have a written consent from the facility agreeing to reimburse our company for services provided.

Home Health Care Facility Full Name: _____

Home Healthcare phone number: _____

Skilled Nursing Facility Name: _____

Skilled Nursing Facility Address: _____

Skilled Nursing Facility phone number: _____ Contact Name: _____

******If this visit is related to an injury******

Date of Incident: _____
Type of Incident:

- Vehicle
- Work
- Other _____

Non-Medical Insurance Information:
Insurance Company: _____
Insurance Claim Number: _____

PATIENT INSURANCE POLICY

Insurance Billing:

- Whether or not we are in-network with your insurance company, they will review the claim and determine the amount they will pay and/or the amount you are responsible for.
- If we do not participate with your insurance company, we **can** bill your insurance for services rendered if you choose that option. **However, if we are Out-of-Network with your insurance, and you prefer we DO NOT bill your insurance company, we will apply a 20% discount to your invoice. You must pay the invoice within 30 days of notification/receipt of invoice for this discount to apply. If you do not pay within the 30-day timeframe, you will then be responsible for the full charges.**
- If we bill your insurance: 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.
- A $50.00 consultation fee is billed to the patient if the provider discusses hearing treatment options.

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

WCHC – 2023-11-03

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

	Jennifer Bebee, Au.D	*Jo-an Mealler, MS*	*Ashley Taylor, Au.D.*	*Alexis Henetz, BS-HIS*

	In-Network	In-Network	In-Network	In-Network
Medicare	X	X	X	
Medicaid	X	X	X	
Rocky Mtn	X	X	X	
United HC	X	X	X	
TriWest	X	X	X	
Medicare Humana Adv Plan	X	X		
UMR	X			
Cigna	X	X		
Humana	X	X		

OUT OF NETWORK INSURANCE 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. *Please see above for in-network insurance companies.*

Please be aware that whether WCHB is in- or out-of-network with an insurance company is not decided by WCHB, but rather by the insurance company and is based on their interpretation of "need of these services" for the general region. There is a high likelihood that WCHB has attempted to be in-network with your insurance company but has been denied due to the insurance company's determination of "need."

If we are out-of-network with your insurance company, this means you can still receive care from our office, but your insurance is unlikely to cover your bill as in-network deductible and in-network benefits do not apply. Due to the nature of being out-of-network, this means that most patients would be subjected to the full bill after billing insurance anyway. You can decide if you want us to bill your insurance for services provided and still pay the full amount, but ***if you opt out of billing your out-of-network insurance, we will apply a 20% discount to your total invoice, if paid within 30 days of notification.***

For example, a typical adult hearing examination expense is $165. With no out-of-network benefits and if the out-of-network deductible hasn't been met, a patient would be expected to pay the full $165 after insurance has been billed. If you choose not to have your out-of-network insurance company billed, you can get a 20% discount on the same services, then having only to pay $132 instead of the total $165.

<u>***Please indicate your preference below***</u>

- ○ My insurance is **In-Network** with the provider. Please bill my in-network insurance.
- ○ Please bill my out-of-network insurance company. I understand anything they do not pay will be my responsibility and I am likely to pay the full amount of the invoice.
- ○ **Please DO NOT bill my out-of-network insurance company. I understand I will receive a discount if my invoice is paid within 30 days of notification, but if paid after 30-days from notification, I will lose my 20% discount. I understand that I cannot request to have my insurance billed at a later date, but that I may request billing information from WCHB in order to submit my own billing claim to an insurance company.**

X _____ _____ _____

Signature (Parent/Guardian) Printed Name Date

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.**

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:

- It is our policy that all past due accounts be sent three statements (90 days).
- 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.

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

- **Insurance Authorization and Policy Acknowledgement:**
  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. I have read and understand the patient insurance policy.
- **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.
- **Payment Policy:**
  I have read and understand the patient payment policy. I understand and agree that payment for services rendered are ultimately my responsibility following any insurance determination. I agree to prompt payment within 30 days of invoice notification.
- **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.

X _____ _____ _____

Signature (Parent/Guardian) Printed Name Date