

PREMIUM
HEARING SOLUTIONS
Hearing health care... The way it was meant to be.

Please provide us with your insurance cards & driver's license. We will make copies for your chart.

Today's Date: _____ How did you hear about us? _____

Patient Name: _____ Sex: M/F (Circle One)
Last First M.I. Marital Status: S M W D
(Circle One)

Address: _____ City: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____

E-Mail Address: _____

Birthdate: _____ Age: _____ Social Security#: _____

Occupation/Type of Work: _____

Primary Care Physician(FamilyDr.): _____ Phone: _____

Address: _____

City/State/Zip: _____

IN CASE OF EMERGENCY, PLEASE PROVIDE CONTACT INFORMATION ON A FAMILY MEMBER OR A FRIEND.

Name: _____ Relationship: _____
Daytime Phone:(____) _____ Evening Phone:(____) _____

HEARING QUESTIONS

What motivated you to come in today?: _____

How motivated are you to improve your hearing? (Circle One)
(not motivated) 1 2 3 4 5 (very motivated)

If our testing indicated a need for hearing instruments, are you prepared to pursue anything today?:
Yes ___ No ___ (Why not?) _____



Insurance Assignment of Benefits: We can accept assignment of benefits with patient authorization.

Yes ___ I would like insurance payment sent directly to the hearing health care provider.

Patient/Insured's Signature: _____

No ___ I do not want insurance payment sent directly to the hearing health care provider.

Patient/Insured's Signature: _____

If you choose to have payment directly sent to us, it does not guarantee they will. On some occasions your insurance company will still send the payment directly to you. If this happens, please submit the payment to our office.

I UNDERSTAND THAT WHEN MY INSURANCE COMPANY QUOTES BENEFITS VERIFYING ELIGIBILITY IT IS NOT A GUARANTEE OF PAYMENT FOR SERVICES RENDERED. I UNDERSTAND THAT IF MY INSURANCE COMPANY DOES NOT PAY REASONABLE AND CUSTOMARY CHARGES OR DENIES CLAIMS FOR SERVICES RENDERED I WILL ASSUME RESPONSIBILITY FOR THESE SERVICES AND REMIT PAYMENT.

Date: _____

Signature

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

By signing this form, you are granting consent to **Premium Hearing Solutions** to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at (248) 435-6811. You have a right to request that we restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Date: _____

Signature

For Office Use Only:

SO _____

BI _____

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HT _____

M/B _____