CONCIERGE
HEARING CARE

New Patient Registration

Full Legal Name:	Date of Birth:	Gender:
Address:		Occupation:
Social Security #:	Cell Phone:	Home Phone:
Email:	Alternate Contact Name & #:	
Preferred Contact Method?	How did you hear about us?	

HIPPA Consent

I have certain rights to privacy regarding my protected health information (PHI) according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize the clinic to use and disclose my protected health information for the purpose of:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from insurance or third-party benefit plans;
- The day-to-day healthcare operations of the clinic such as quality assessments and provider certifications.

I have been informed a copy of the clinic's Notice of Privacy Practices will be provided to me upon request. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

PHI Release Authorization

I authorize the below individuals, providers and/or facilities to have access to my protected health information (PHI) from Concierge Hearing Care:

Name	**Relationship to Patient**	**Phone #**

Insurance Consent & Financial Agreement

I hereby authorize the clinic to file claims to my medical insurance and third-party benefit policies, with all insurance payments of benefits to be paid directly to the clinic.

- If my insurance plan requires a referral and/or an order from a physician, it is ultimately my responsibility to obtain. Insurance may deny a claim without prior authorization, at which point the patient will become financially responsible.
- In the event my insurance plan is out of network, and/or this clinic is not a participating provider, I understand I will be billed upfront for services. If no out of network benefits exist, I understand I am fully responsible for payment.
- This clinic is a non-participating Medicare provider; I understand that I must pay upfront for my services if I have Medicare. A bill may be sent to Medicare on my behalf; any reimbursement is subject to Medicare guidelines.
- This clinic is not a Medicaid provider.
- I understand my insurance policy is a contract between my carrier and I; if a service is non-covered, the clinic is unable to make the carrier pay.
- I accept full responsibility of all services and charges; in the event that I have no insurance or it is inactive.

128 Chesterfield Commons East Rd - Chesterfield, MO 63005 - P: (636) 778-1168 F: (636) 216-6256

CONCIERGE HEARING CARE

Insurance Consent & Financial Agreement Continued

• I accept full responsibility for all excess charges and balances not paid for by my insurance company or third-party benefit plan, and in the event they have not paid my claim within 90 days, it becomes patient responsibility.
• Charges 90 days past due are subject to late fees.
• All appointments require 24-hour notice for cancellation; a $35 no-show fee may be added to your account.
• A $25 fee will be assessed for returned checks.
• For minors, the parent/guardian consenting to treatment is financially responsible.
• For self-pay patients, payment is expected at the time of service, unless other arrangements have been made.
• I understand I am responsible for the timely payment of my account. If an account is forwarded to collections, it will be patient responsibility to pay the costs incurred for the collection agency.
• This clinic accepts cash, checks, Visa, Mastercard, Discover, American Express and Care Credit.

Primary Insurance Information

Insurance Carrier:

Subscriber/Policy ID #:

Group/Plan #:

Is the Patient Primary Subscriber? If not, fill out below:

Primary Subscriber Full Legal Name, DOD & Gender:

Relationship to Patient:

Address & Phone #:

Secondary Insurance Information

Insurance Carrier:

Subscriber/Policy ID #:

Group/Plan #:

Is the Patient Primary Subscriber? If not, fill out below:

Primary Subscriber Full Legal Name, DOD & Gender:

Relationship to Patient:

Address & Phone #:

Consent for Treatment

I voluntarily give my informed and valid consent to Concierge Hearing Care for the purposes of:

•Screening •Assessment •Consultation •Treatment

I understand the nature about the proposed service(s) offered and recommended to me, as well as any associated benefits and risks. I may revoke this consent at any time. Should any change in guardianship or power of attorney occur, the clinic will be notified in a timely manner.

Print Patient Name & DOB

Relationship to Patient

Patient Signature
(or Parent/Legal Guardian)

Today's Date
(MM/DD/YYYY)

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