CONSTANCE BROWN HEARING CENTERS

Please present your insurance card at the time of check-in.

Payment is expected at the time of service.

Date	**PATIENT INFORMATION**	CBHC#	
Last Name	First Name		MI
Name you prefer to be called			
Birth Date	Gender F M	Spouse's Name	
Street			
City	State	County	Zip
Home Phone	Cell Phone	Work Phone	Leave message Y N
Email	Preferred contact: Home Cell Work Email		
Employer	Occupation		
Child's School	School District		
Primary Care Physician	Address		
I give consent to send a copy of my records to the Primary Care Physician listed above Y N			
Race/Ethnicity (optional): African Amerian Asian or Pacific Islander American Indian Hispanic Caucasian			

EMERGENCY CONTACT

Contact Name	Relationship	
Street		
City	State	Zip
Home Phone	Cell Phone	

PARENT / GUARDIAN (RESPONSIBLE PARTY IF UNDER 18)

Name	Name
Birth Date	Birth Date
Street	Street
City/State/Zip	City/State/Zip
Phone	Phone
Relation to patient	Relation to patient
Employer	Employer

REFERRAL SOURCE

Self Paper Ad Radio Ad Friend / Family ______________

Physician (name) ______________ Other (list) ______________

INSURANCE INFORMATION (MUST BE COMPLETED)

Is the patient covered by insurance? Y N	
Primary Insurance Information	Secondary Insurance Information
Insurance	Insurance
ID#	ID#
Group#	Group#
Insured Name	Insured Name
Relation to patient	Relation to patient
Policyholder Birth Date	Policyholder Birth Date
Occupation	Occupation

PLEASE READ AND COMPLETE REVERSE SIDE - SIGNATURES REQUIRED (HIGHLIGHTED AREAS)

CONSTANCE BROWN HEARING CENTERS

Date	Patient Name	CBHC#

AUTHORIZATION AND RELEASE

By signing this consent form, I acknowledge that I have read, understand, voluntarily consent to, and authorize the following:

AUTHORIZATION OF TREATMENT

I authorize the administration and cost of all services for myself and my dependents.

GUARANTEE OF PAYMENT

I understand that I am financially responsible for the fees for all services rendered (and equipment and supplies provided to me). I guarantee payment of the portion of my account for which I am responsible within ninety (90) days of notification of the balance. I agree that, in the event I default and do not pay my balance, reasonable costs of collection [limited to no more than forty percent (40%) of the delinquent balance] and/or reasonable attorney fees may be added to the amount due on the account and I agree to be financially responsible for those additional charges.

Patient/Guardian Signature Date

RELEASE / OBTAIN RECORDS / INFORMATION

I authorize Constance Brown Hearing Centers to release/obtain verbally, electronically and/or in writing confidential information obtained during the course of my examination and/or treatment to any person or entity including my insurance carrier, employer (if treatment is related to the employment), and/or other healthcare provider(s) for purposes of treatment, payment of charges, quality assurance and utilization review. I understand that should I choose not to release my records to a specific entity and/or person(s), I must specifically state so in writing. This assignment and authorization will remain in effect until revoked in writing by me.

Patient Name Birth Date

Please also share my records with (name & address):

Patient/Guardian Signature Date

RECEIPT OF PRIVACY PRACTICES

By signing this consent form, I acknowledge that a copy of the Notice of Privacy Practices of Constance Brown Hearing Centers is available to me upon request.

Patient/Guardian Signature Date

FINANCIAL ASSISTANCE

Constance Brown Hearing Centers will help find financial assistance or adjust fees for those in need.

Do you wish to be considered for this assistance? __________ Yes __________ No

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__________ Individual refused to sign

__________ Communications barrier prohibited obtaining the acknowledgement

__________ Other (please specify)