CONSTANCE BROWN HEARING CENTERS

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

Payment is expected at the time of service.

Date	**PATIENT INFORMATION**	CBHC#
Last Name	First Name	MI
Preferred Nickname	Preferred Pronouns: she/her/hers he/him/his they/them/their zie/hir/hirs	
Date of Birth	Legal Gender: M F	Spouse's Name
Address	City	State
Zip / County	Email	
Home Phone	Cell Phone / Cell Carrier	Leave Message: Y N
Work Phone	Preferred Method of Contact: Home Cell Work Email	
Employer	Occupation	
Child's School (if patient)	School District	
Primary Care Physician	Address	
Race/Ethnicity: American Indian Asian Black or African American Hispanic or Latino Mixed MENA (Middle Eastern or North African) Pacific Islander White Other		

EMERGENCY CONTACT		
First & Last Name	Relationship	
Address		
City	State	Zip
Best Phone Number to Call in Case of Emergency		

PARENT / GUARDIAN (RESPONSIBLE PARTY IF UNDER 18)	
Name	Name
Date of Birth	Date of Birth
Address	Address
City/State/Zip	City/State/Zip
Phone	Phone
Relation to Patient	Relation to Patient
Employer	Employer

HOW DID YOU HEAR ABOUT US

Self Magazine Radio Google Facebook Healthy Hearing Phonebook Health Fair

Physician (name) _____ Friend / Family _____

Other (list):

INSURANCE INFORMATION (Complete unless we have a copy of your card)	
Is the patient covered by insurance? Yes No	
Primary Insurance	Secondary Insurance
Policyholder Name	Policyholder Name
Policyholder Date of Birth	Policyholder Date of Birth
Relation to Patient	Relation to Patient
ID#	ID#
Group#	Group#

PLEASE READ AND COMPLETE REVERSE SIDE - SIGNATURES REQUIRED

CONSTANCE BROWN HEARING CENTERS

Date	Patient Name	CBHC#

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.

Signature X_____ **Date** _____

Parent/Guardian Signature if Minor X_____ **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

RECORD RETENTION

Constance Brown Hearing Centers complies with federal regulations and state law by retaining medical records in either written or electronic storage for 7 years after the date of service.

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)

Revised 6.7.2021

CONSTANCE BROWN HEARING CENTERS
ADULT CASE HISTORY

Date	**PATIENT INFORMATION**	CBHC#
Name	Birth Date	Age
Employer		
Occupation	Retired? Yes No	

PURPOSE OF VISIT

RISK INDICATORS	**YES**	**NO**
Difficulty hearing (without hearing aids)?		
On a scale of 1-10, with 1 being the worst and 10 being the best, how would you rate your overall hearing ability? 1 2 3 4 5 6 7 8 9 10 (Please circle)		
Is one ear better than the other? Right or Left (Please circle)		
Do you wear hearing aids? Past or Currently (Please circle)		
Noises/ringing/buzzing in your ears (Tinnitus)?		
Dizziness?		
Ear pain, ear drainage, fullness or pressure in the ear?		
Allergies or sinus problems?		
Family history of hearing loss?		
Exposure to loud noises?		
Syndromes or developmental delay?		
DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING	**YES**	**NO**
Cancer?		
Diabetes?		
Heart disease?		
High blood pressure?		
Kidney disease?		
Tobacco use?		

Please list any other chronic health conditions you are being treated or monitored for:

MEDICATIONS	**DOSAGE FREQUENCY**		**ORAL/INJECTED/TOPICAL, ETC.**
Include over-the-counter	What strength?	How often?	

DO YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING YOUR HEARING?

PLEASE READ AND COMPLETE REVERSE SIDE - SIGNATURES REQUIRED

Revised 6.7.2021

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 _____ Date of Birth _____

Please also share records with (name & address):

Physician

Spouse

Family Member

School

Other

Signature X_____ **Date** _____

Parent/Guardian Signature if Minor X_____ **Date** _____

CONSTANCE BROWN HEARING CENTERS

Financial Policy

Date_____

Patient Name_____ CBHC#_____

We are committed to providing you with the best possible hearing health care. The following information is provided to avoid any misunderstanding or disagreement concerning payment for our services, equipment and supplies.

Our office participates with many insurance plans. If you are a member of one of these plans, our office will submit a claim for services. If we are not a participating provider for your insurance, upon payment from you, we will provide an itemized receipt for you to submit to your insurance for reimbursement.

It is your responsibility to:

- Give us your current insurance information and provide your insurance card at each visit.
- Pay your full co-pay at each visit.
- Pay any balance not covered by your plan, including any deductibles, copays, coinsurance, and non-covered services.
- Know the benefits, coverage, and terms of your insurance.

Some services may not be covered under your insurance plan. It is your responsibility to pay any balance not covered. You agree to be financially responsible for the fees for all services rendered (as well as equipment and supplies provided). You guarantee payment of the portion of your account for services covered and non-covered, within ninety (90) days of notification of the balance. **You also agree that in the event that you default and do not pay your 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 you agree to be financially responsible for those additional charges.**

Verification of insurance eligibility is not a guarantee of payment. Insurance benefits/coverage can only be determined when a claim is submitted for benefit consideration. Your insurance may only pay for services that it determines to be "reasonable and necessary". In the event your insurance determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" by their program standards, your insurance may deny payment for that service. You will be responsible for payment. Appeal responsibilities will not be assumed by Constance Brown Hearing Centers.

If the patient is a minor, the parent or guardian must sign this form and is responsible for any payment due at the time of service. Bring the necessary authorization to treat and insurance card(s).

I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or to the party who accepts assignment. I agree to be responsible for my insurance deductibles, copays, coinsurance, and non-covered services.

Please print name X _____

Patient/Guardian Signature X_____ **Date** _____