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
PEDIATRIC CASE HISTORY

Date	**PATIENT INFORMATION**	CBHC#	
Name	Birth Date		Age
Hospital of Birth			
Name of School		School District	

PURPOSE OF VISIT		
Why does your child need a hearing test?		
HEARING / HEALTH HISTORY	**YES**	**NO**
Did your child pass the newborn hearing screen?		
Has your child had other previous hearing tests?		
Is there a family history of hearing loss?		
Do you have concerns about your child's hearing?		
Do you have concerns about your child's speech and language development?		
Is your child currently receiving speech, occupational, or physical therapy?		
Does your child wear a hearing aid?		
Has your child had ear infections?		
Has your child had (please circle): PE Tubes Tonsils Removed Adenoids Removed If so, when?		
Birth history of any of the following (please circle):	**YES**	**NO**
Assisted Ventilation Birth Defect Blood Transfusion Breathing Difficulties Cleft Lip/Palate Jaundice/Yellow Low APGAR Score Medications Premature Birth		
In utero infections such as: CMV Herpes Rubella Syphilis Toxoplasmosis		
Was your child in neonatal intensive care (NICU)?		
Developmental milestones on track? (sit, crawl, roll over, walk, first word)		
Any of the following **health/medical problems**? (please circle)	**YES**	**NO**
ADD/ADHD Allergies Autism Balance Disorders Cancer Genetic Disorder/Syndrome Head Trauma Heart Problems Kidney Problems Meningitis Seizures		
EDUCATIONAL HISTORY	**YES**	**NO**
Does your child have an IEP/504 or receive accommodations in school?		
Does your child have difficulty concentrating or paying attention in school?		

Please list current medications		

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** ________________

Revised 6.7.2021

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** _____________

Reviewed 11.20.2018