Flatirons AUDIOLOGY, INC.

300 Exempla Circle Suite 365
Lafayette, CO 80026
303-664-9111

# PATIENT INFORMATION

**PLEASE PRINT**

**Choose One: Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐** **Today's Date:** _____

**Patient Name (Full Legal):** _____ **Sex: M F**
First MI Last

**Date of Birth:** ____/____/____ **Age:** _____ **Preferred Name:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Phone:** _____ _____ _____
**Home** **Cell** **Work**

**Marital Status:** Single Married Domestic Partner Divorced Widowed

**Employment Status:** Full-Time Part-Time Retired Active Military Unemployed Student

Emergency Contact: _____ Relationship: _____

Phone(s): _____ _____

**Employer:** _____ **Occupation:** _____

**How did you hear about Flatirons Audiology?** _____

**If the patient is under 18, a parent and/or guardian must provide the following:**

Name: _____ Relationship to patient: _____

Address (if different): _____

Phone: _____

**Primary Care Physician:** _____ **Phone:** _____

- May we send a report to your Primary Care Physician? Yes No

**ENT/Other Care Provider:** _____ **Phone:** _____

- May we send a report to your ENT/Other Care Provider? Yes No

****PLEASE NOTE - If a referral was received from a physician for this appointment, a report will automatically be provided to that physician.**

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## INSURANCE:

Please complete this section AND provide your card(s) so that a copy can be made. Without the proper information for billing we will be unable to file a claim on your behalf and you will be responsible for all charges incurred for this and future visits. We will also require a copy of your driver's license or another form of picture identification.

Primary Ins: _____ Member ID: _____

Secondary Ins: _____ Member ID: _____

**If the patient is not the primary insured - please complete the following:**

Primary Insured: _____ Relationship to Patient: _____

Address (if different): _____

Date of Birth: _____ Employer: _____

Phone: _____

☐ **I DO NOT HAVE INSURANCE AND WILL SELF-PAY FOR ALL SERVICES**

**PERMISSION TO CONTACT YOU:**

Flatirons Audiology may contact you after your visit to provide information regarding your appointment and to schedule and/or confirm future appointments. These permissions will remain in effect until revoked by you in writing.

Detailed messages may be left, either by voicemail or with anyone answering the phone, at: (Check all that apply) Home ☐ Cell ☐ Work ☐

May we contact you by email? If so, please provide your email address.

Email Address: _____

* For use by this office only for appointment and/or other office related information

Our office sends quarterly newsletters and other informational letters (e.g., annual hearing test reminders) through the mail. May we add you to our mailing list? **YES NO**

Do we have permission to speak with anyone else regarding your appointments, test results, hearing aids, or billing and insurance information? If so, please complete the following:

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

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**Please read and initial each of the items listed below**

**Initials**

_____ For your convenience we accept Cash, Check, Visa, MasterCard and Discover. Any payments made by check will have a $25 returned check charge added to the account if that payment is dishonored by your bank for any reason.

_____ We understand that sometimes you may be running late for your appointment. Unfortunately, we have scheduled patients throughout the day and may not be able to see you if you arrive more than 10 minutes late for your scheduled appointment time. We will make every effort to accommodate you if time allows, but we may need to reschedule your appointment.

_____ In the event that you need to cancel or reschedule an appointment, we do ask for 24 hours notice. If you fail to show up for an appointment or cancel/reschedule with less than 24 hours notice, you may be charged up to $75 depending on the length of the scheduled appointment. Exceptions will be made depending on the circumstances. The number to call for all appointments is **303-664-9111.**

I have read and understand all of the above information. I certify that the information I have provided is true and correct to the best of my knowledge.

_____ _____

**Patient or Responsible Party Signature** **Date Signed**

_____

**Printed Name**

## Notice of Privacy Practices Acknowledgement - Please read and sign below

This is to acknowledge the receipt of Flatirons Audiology's Notice of Privacy Practices. In accordance with the requirements of the federal regulation "HIPAA Privacy Rule", we are requesting your signature as verification that you have been given the opportunity to review our privacy practices. You may request a printed copy to keep for your records. If the patient refuses to sign this acknowledgement, this practice is not obligated to treat the patient.

_____ _____

**Patient or Responsible Party Signature** **Date Signed**

_____

**Printed Name**

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# INSURANCE INFORMATION AND ASSIGNMENT OF BENEFITS

**INSURANCE PATIENTS - Please read and initial the following:**

**Initials**

_____ Your insurance coverage is an agreement between you and your insurance carrier. Flatirons Audiology is unable to guarantee coverage and/or payment for services provided by our office.

_____ As a courtesy to our patients, Flatirons Audiology will submit claims on your behalf for services rendered. If your insurance fails to make a payment on the claim within 90 days, you will be responsible for the balance in full at that time.

_____ There are services that we provide that are not billable to insurance. Flatirons Audiology agrees to inform you in advance of these particular services and the cost associated with each one. You have the option to decline these services. If you choose to proceed, payment will be due at the time of the appointment.

_____ Once an Explanation of Benefits (EOB) has been received from your insurance, if there is an amount due from the patient, a statement will be mailed immediately to the address on file. The balance is due upon receipt of the statement. There may be a monthly rebilling fee/late fee added for past due amounts. If you need to make payment arrangements please call our office.

_____ Flatirons Audiology reserves the right, after 120 days following the initial invoice date, to forward all outstanding balances to either a third party collection agency and/or small claims court for enforcement of this agreement. In the event that this happens, you will be responsible for all fees associated with this process. We also reserve the right to discontinue care for patients who do not meet their financial obligations.

I, the undersigned, certify that I (or my dependent) have insurance coverage with Medicare or the insurance company listed on Page 2 of the Patient Information sheet and assign directly to Flatirons Audiology, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges regardless of insurance coverage. I hereby authorize Flatirons Audiology to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

**Patient or Responsible Party Signature** **Date Signed**

_____

**Printed Name**