Anchorage Audiology Clinic, LLC

3730 Rhone Circle, Suite 104
Anchorage, AK 99508
(907) 563-8008

3750 E. Country Field Circle, Suite B
Wasilla, AK 99654
(907) 563-8008

Patient's Full Name _____

Parent's/Guardian's Name if Patient is Minor _____

Address _____

City _____ **State** _____ **Zip Code** _____

Age _____ **Date of Birth** _____ **Last Four Numbers of SSN of Patient or Guardian** _____

Telephone Number **Work** _____ **Home** _____ **Other** _____

Patient's (or Guardian's) Employer _____

Employer's Address _____

Referred By _____

We are not a Participating Provider in any insurance network, other than Medicare and Medicaid. We require payment in full at the time of service, regardless of insurance, unless you have Medicare, Medicaid or an approved Third Party Payer. Your insurance is a contract between you, your employer and your insurance carrier. We are not a party of that contract. However, in appreciation of your coming to our office, we'd be happy to send in your insurance paperwork for you. We request the insurance to assign benefits directly to the Subscriber.

☐ **I understand the payment policy for Anchorage Audiology Clinic, LLC that is stated in this section.**

Medicare does not provide coverage for hearing aids, or hearing aid evaluations. These are separate services from an audiological evaluation, which Medicare may consider coverage for. Medicare does require a physician's referral. Medicare pays for services that are considered medically reasonable and necessary to the diagnosis and treatment of a patient's condition. You will be given a Notice of Exclusion of Medicare Benefits form for any non-covered Medicare service. Please refer to your Medicare Benefits Manual for further information.

Patients are ultimately responsible for their bill – regardless of insurance. All accounts over 90 days will be turned over to a collection agency. If an inaccurate address is given, and the mail is returned, the bill will be referred immediately to a collection agency. There is a $25.00 charge on all NSF checks.

We accept assignment with Medicare and must bill them directly for Medicare covered audiological evaluations. Please provide a copy of your Medicare card.

If you have Medicaid, please provide a copy of your Denali Care card.

If you would like for us to send in your primary insurance paperwork for you, or if you have insurance primary to Medicare or Medicaid, we will need a copy of your primary insurance card.

Patient's Full Name _____ Date of Birth _____

Consent for Treatment

By signing below, I give my consent for examination and treatment for myself. If patient is a minor, by signing I give consent for examination and treatment for the above minor patient.

Consent for Use and Disclosure of Protected Health Information

By signing below, I give my consent for Anchorage Audiology Clinic, LLC to use and disclose my protected health information (PHI) about me to carry out treatment, payment and health operations. (The Notice of Privacy Practices provided describes such uses and disclosures more completely). I authorize Anchorage Audiology Clinic to release information requested with regard to processing my claims.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Anchorage Audiology Clinic, LLC reserves the right to revise the Notice of Privacy Practices at any time.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Anchorage Audiology Clinic may decline to provide treatment to me.

Agreement to terms of Anchorage Audiology Clinic

By signing below, I acknowledge that I have read and understand the business practices stated in this information sheet for Anchorage Audiology Clinic, LLC.

_____ _____

Signature of Patient or Guardian **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

☐ **By checking this box and signing below, I acknowledge that I reviewed a copy of Anchorage Audiology Clinic, LLC's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice.**

_____ _____

Printed name of patient or personal representative **Date**

_____ _____

Signature of patient or personal representative **Date**

HISTORY

Do you experience ringing or other noises in your ears? **Yes** **No**

Do you experience dizziness? **Yes** **No**

Are you experiencing pressure or fullness in your ears? **Yes** **No**

Have you had drainage from your ears in the past three months? **Yes** **No**

Do you have any ear pain, swelling or tenderness? **Yes** **No**

Have you had any ear surgeries? **Yes** **No**

Do you often ask others to repeat themselves? **Yes** **No**

Do you find that words are unclear, even when they seem loud enough? **Yes** **No**

Do you have difficulty on the telephone? **Yes** **No**

Do others complain about the TV being too loud? **Yes** **No**

HEARING NEEDS ASSESSMENT

If a hearing loss is discovered, are you ready for help? **Yes** **No**

In what setting does your hearing loss bother you the most? _____

With 10 being very motivated and 1 not at all, how motivated are you to improve your hearing? _____

Rank the following in order of importance regarding a hearing device. Use 1, 2, and 3, (with 1 being *most* important and 3 being *least* important):

_____ Sound Quality & Clarity

_____ Cost

_____ Appearance

Do you currently wear hearing aids? **Yes** **No**

Have you ever worn them? **Yes** **No**

Additional Comments: _____

_____

Name: _____ DOB: _____ Date: _____