Audiology & Hearing Aid Center

Cynthia Olsen, AuD, CCC-A
Dennis Bell, Hearing Specialist
Patrick Brown, Hearing Specialist
1740 North Milwaukee Street
Boise, ID 83704
208-658-0238

Patient Information Date _____

Last Name _____ First Name _____ Middle _____ ☐ F ☐ M

Address _____ City _____ State _____ Zip _____

Cell or Home Phone ( ) _____ -- _____ Work Phone ( ) _____ -- _____

Date of Birth _____ /_____ / _____ Age _____ ☐ Married ☐ Single ☐ Widow(er)

E-mail Address _____

Occupation _____ If retired, what kind of work did you do? _____

Who is with you today? _____ Relationship _____

Family Physician (Requirement for Medicare) _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

If you were referred to us, who may we thank? _____

Insurance Carrier _____ I.D. No./Policy No. _____

Secondary Insurance Carrier _____ I.D. No./Policy No. _____

As required by law, I have been given the opportunity to read the notice describing information about privacy practices followed by Audiology & Hearing Aid Center.

Signature _____

Medical History

Do you have any allergies? ☐ Yes ☐ No If yes, please list _____

Are you an insulin-dependent diabetic? ☐ Yes ☐ No

Are you taking any blood thinners? ☐ Yes ☐ No If yes, please list _____

Do you have any arthritis? ☐ Yes ☐ No

Have you been examined by a doctor in the past 6 months? ☐ Yes ☐ No

Have you received any medical or surgical treatment for your hearing loss? ☐ Yes ☐ No

Audiology & Hearing Aid Center

Financial Policy

Thank you for choosing Audiology & Hearing Aid Center. We strive and are committed to providing you with the highest quality of care. To ensure effective communication between you and our practice, we have adopted the following financial and insurance policies.

1. All charges, regardless of the insurance coverage, are the patient's responsibility. Patients are responsible for knowing what services are covered under their insurance plan. Audiology & Hearing Aid Center must bill the visit according to the services provided.

2. Patients will be asked to provide their current insurance card and mailing address at the time of service. It is the patient's responsibility to inform our office of any insurance, address, or telephone number changes.

3. Full payment of the patient's estimated portion is expected at the time of service. This includes copays, deductibles, and co-insurance. Patients are responsible for paying the part of the bill that is not covered by their insurance company.

4. Once insurance has processed, patients will receive monthly statements asking to clear the balance on their account. If payment arrangements are necessary, it is your responsibility to contact our billing department to establish a reasonable plan.

5. Ninety days following the initial statement, if account remains delinquent, it will be sent to an outside agency for collections.

6. I authorize the release of any information necessary to determine liability for payment to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled to Audiology & Hearing Aid Center. The assignment will remain in effect unless revoked in writing.

I have read and understand the Financial Policy and agree to meet all financial obligations.

Signature Date