LeMay HEARING & BALANCE

Patient Information

Patient Name _____ Date ____/____/____
First Middle Last MM DD YYYY

Home Phone ( ) _____ Cellphone ( ) _____

Work Phone ( ) _____ Sex: M F

Email Address _____

Address _____
Street City State Zip

Secondary Address _____
Street City State Zip

Date of Birth ____/____/____ Occupation _____
MM DD YYYY (If retired, prior occupation)

Marital Status: Married Single Other _____

Name of Spouse, if applicable _____

Emergency Contact _____
Name Phone Number

Relation to Patient _____

Primary Care Physician _____ Phone ( ) _____

How did you hear about us? (Please circle)

Direct Mail Newspaper Ad Telephone Repeat Patient

Website Yellow Pages Referred by a Friend: _____
Name

Physician Referral _____ Other _____
Name

Billing Information

_____ The doctor is a non-preferred provider for my insurance. I understand my out-of-pocket expenses will be higher and I am responsible for the payment of services.

_____ I do not have insurance and will pay for my services at the time of my visit.

_____ I have insurance with which the doctor is contracted. The billing staff will submit my claim for payment to my insurance company.

Are you currently under hospice care? Yes/No

Primary Insurance

Carrier _____

Subscriber's Name _____

Subscriber's Birth Date _____

ID # _____

Group # _____

Effective Date _____

Address for claims submission _____

_____

_____

Secondary Insurance

Carrier _____

Subscriber's Name _____

Subscriber's Birth Date _____

ID # _____

Group # _____

Effective Date _____

Address for claims submission _____

_____

_____

Legal Case: ☐ Yes ☐ No

Full payment is due today. We are happy to provide you with a copy of the charges and test results.

Name, Address, Phone # of Legal Provider

_____

_____

Claim # _____

I authorize the processing of my medical insurance claim(s) by LeMay Hearing & Balance. My signature authorizes the payment to LeMay Hearing & Balance of all medical and surgical benefits to which I am entitled. I further authorize LeMay Hearing & Balance to contact my insurance carrier(s) and to release all information necessary to secure payment. I recognize my financial obligation to pay any co-payments, co-insurance, deductible and non-covered services. Co-payments and fees for services for non-preferred insurance providers are due at the time of service. Full payment for services is expected within 90 days. An account balance 90 days and older for which patient liability has been determined will accrue finance charges not to exceed 10% per annum.

My signature indicates my acknowledgment and acceptance of the above policies.

_____ _____

Patient/Guarantor's Signature Date