Biggert's Hearing Instruments, Inc.
Patient Registration Form

Patient Name: _____
(Last) (First) (MI)

Date of Birth: _____/_____/_____ Age:_____ ***Gender***: ○ Male ○ Female

Marital Status: ○ Single ○ Married ○ Widowed ○ Divorced ○ Other

Employment Status: ○ Employed ○ Student ○ Retired ○ Unemployed

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Home Phone: _____ Cell: _____ Work: _____

Emergency Contact: _____ Relationship to Patient: _____

Emergency Phone: _____ Primary Care Physician: _____

Mail: May we send occasional marketing materials related to audiological products or services?
○ Yes ○ No

Insurance Information:
Copies of your insurance card(s) are required to process any insurance claims. Please note that our office files insurance claims as a courtesy. Please allow us to make a copy of our insurance card(s).

PRIMARY INSURANCE:
Insurance Provider: _____

Policyholder's Information:
Name: _____
DOB: _____ Relationship to Patient: _____

SECONDARY INSURANCE (IF APPLICABLE):
Insurance Provider: _____

Policyholder's Information:
Name: _____
DOB: _____ Relationship: _____

Referred: How did you hear about us? ○ Mail ○ Newspaper Ad ○ Insurance

○ Yellow Pages ○ Health Fair ○ Website ○ Other _____

○ Physician, Who? _____ ○ Friend, Who? _____

Confidential Information:
Please check and name the individual(s), in addition to your emergency contact, with whom we may share your confidential health information, if needed.

- ○ Family Member(s): _____
- ○ Care Facility: _____
- ○ Other (e.g. POA): _____

Please list ALL current medications. You may provide a list for us to copy.

Medication	Dose

What motivated you to visit us today? _____

In what two situations would you most like to hear and understand better?

1. _____ **2.** _____

Hearing Aid Experience:
○ YES, I have a hearing aid(s) for my: ○ right ear ○ left ear *Date of Purchase:* _____
○ YES, I wear my aid(s): ○ daily ○ occasionally ○ never
○ YES, I have inquired about hearing aid(s) at other offices.
○ YES, I tried a hearing aid(s) but I returned it.
○ NO, I have never used a hearing device.

Medical and Audiological History (Please circle Yes or No and explain so that we can understand your ear and hearing health history):
Have you ever seen an otolaryngologist (ear doctor)? Yes No
When: _____ Reason: _____
Have you ever had ear surgery? Yes No
If yes, explain: _____
Have you experienced any head trauma? Yes No
If yes, explain: _____
Do you have a family history (parents, siblings, etc.) of hearing loss? Yes No
Exposed to loud noise ANY time in your life? (factory, power tools, firearms, military) Yes No

Have you had your hearing tested before?			Yes	No
Do you have a problem with wax build up in your ears?			Yes	No
Have you ever been diagnosed with diabetes?			Yes	No
Have you ever been diagnosed with hypertension (high blood pressure)?			Yes	No
Have you ever been diagnosed with heart disease?			Yes	No
Do you hear better in one ear?	Yes, Right is better.	Left is better.	No, Same in both ears.	

Are you experiencing any of the following? (circle your response):

Ringing, buzzing in the ears (Tinnitus)	Yes	Right	Left	Both	No
Sudden/rapid loss of hearing in the last 90 days	Yes	Right	Left	Both	No
Drainage from the ear(s)	Yes	Right	Left	Both	No
Pain in your ear(s)	Yes	Right	Left	Both	No
Dizziness - acute or chronic? If yes, describe: _____					No

How are you hearing in the following listening situations? (circle one):

Quiet Room (1 to 2 people)	Good	Fair	Poor	N/A
Telephone	Good	Fair	Poor	N/A
Television	Good	Fair	Poor	N/A
In the Car	Good	Fair	Poor	N/A
Groups (4 to 6 people)	Good	Fair	Poor	N/A
Large Groups (15-100 people)	Good	Fair	Poor	N/A
Religious Gathering	Good	Fair	Poor	N/A
Meeting/Lectures	Good	Fair	Poor	N/A
Restaurants/Background noise	Good	Fair	Poor	N/A
Work Place	Good	Fair	Poor	N/A

The following questions are <u>REQUIRED</u> for patients who have Medicare:

In the last two weeks have you experienced the following:		
Little interest or pleasure in doing things	Yes	No
Feeling down, depressed, or hopeless	Yes	No
Do you currently use tobacco in any form (smoke, chew, vapor)?	Yes	No

Our Policies:

We believe in, and strive to provide a convenient location with ample parking and expect our staff to always be professional, courteous and helpful. To provide you with the highest level of service, please rate your experience with the following areas:

Location and accessibility:	○ Excellent	○ Average	○ Poor
Adequate parking:	○ Excellent	○ Average	○ Poor
Convenience of appointment time:	○ Excellent	○ Average	○ Poor
Friendly greeting:	○ Excellent	○ Average	○ Poor
Welcoming environment:	○ Excellent	○ Average	○ Poor

What can we do to make your next visit more comfortable? _____

_____

Our Payment Policy:
Biggert's Hearing Instruments' goal is provide you with the highest level of professional audiological care possible while keeping costs to a minimum. In an effort to provide quality medical services, we have established the following credit and payment policies.

Financial Responsibility: Patients are financially responsible for all services rendered regardless of insurance coverage.
Insurance: We submit claims on your behalf to your primary and secondary insurance carriers as a courtesy. Your insurance contract is between you and your carrier, but our office staff will check your coverage and benefits for you upon request. If you have additional questions or concerns about your insurance coverage, please call your carrier. For the purchase of hearing aids or other services covered by your insurance carrier(s), excluding medically necessary hearing evaluations for patients with Medicare, you are responsible to ***pay in full*** the amount owed Biggert's Hearing Instruments, unless other arrangements have been made. Our office will then file your claim to your insurance carrier(s) for ***your reimbursement***.
Co-payments: Co-payments (if applicable) are due at the time of service.
Non-Covered Services: Payment in full is required at the time of service for those services not covered by your insurance. Exception to this policy includes the payment for hearing aids, which may be split into two payments. Other exceptions to this policy may be made only by the Owner at her discretion.
Medicare: Biggert's Hearing Instruments accepts Medicare. We will submit your claim directly to Medicare and will bill your secondary insurance after Medicare has paid their portion. You are responsible for any allowed amount that is not paid by Medicare and/or your secondary insurance. Any remaining patient balance is due within 30 days of the date you receive your statement.
Medicaid: Biggert's Hearing Instruments accepts payment by Medicaid for those patients under the age of 21. We will file your claim to Medicaid after the proper pre-authorizations have been received. It is the patient's (or responsible party's) responsibility to provide Biggert's Hearing Instruments with a copy of the patient's current Medicaid card annually.
Uninsured: We require self-pay (uninsured) patients to pay at the time of service.
Additional Fees: A rebilling charge of $5 will be added to all accounts with unpaid patient responsibility balances over 30 days. A cancellation fee of $25 will be billed to any patient after cancelling an appointment three consecutive times.
Payment Types: Biggert's Hearing Instruments accepts cash, personal checks, cashier's checks, Visa, MasterCard, Discover, and Care Credit. Credit card payments cannot be accepted over the phone and must be made in person.

I have read and understand the Biggert's Hearing Instruments Payment Policy. My signature below indicates that I accept this policy and agree to abide by the terms for my treatment with Biggert's Hearing Instruments.

_____
Printed name of patient or personal representative

_____ _____
Signature of patient or personal representative Date

Privacy Policy (HIPAA):

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that Biggert's Hearing Instruments (referred to below as "BHI") will use and disclose **protected health information** about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health related information.

I understand and agree that BHI may **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative, and business functions that support my audiologist's efforts to provide me with, arrange, and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how BHI will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made, the information practices followed by the employees, staff, and other office personnel of BHI, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or summary of the most current version of BHI's Notice of Privacy Practices in effect will be posted in the waiting/reception area and will be posted on the BHI website at the following address: www.biggertshearing.com/patientforms.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that BHI is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received or denied a copy of the Notice of Privacy Practices.

_____

Printed name of patient or personal representative

_____ _____

Signature of patient or personal representative Date

BIGGERT'S
HEARING INSTRUMENTS