Patient Information

Hearing ~ Balance ~ Health
…live your best life…

NARO AUDIOLOGY & HEARING SOLUTIONS

Contact Information:

Patient Name: _____ **DOB:** _____
[First] [MI] [Last] [MM / DD / YYYY]

Patient's SSN: _____ **Sex:** ☐ Male ☐ Female **Age:** _____

Mailing Address: _____
[Appt / Unit No.] [Street No.] [Street]

_____
[City] [State] [Zip]

Physical Address: _____
☐ *Check if same as Mailing Address*
[Appt / Unit No.] [Street No.] [Street]

_____
[City] [State] [Zip]

Email Address: _____

Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Divorced

Spouse's Name: _____

Phone Number(s):
[Home] _____
[Work] _____
[Cell] _____

Alternate Contact: *Check if Primary Contact* ☐

Alternate Name: _____
[First] [MI] [Last]

Mailing Address: _____
[Appt / Unit No.] [Street No.] [Street]

_____
[City] [State] [Zip]

Email Address: _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Relative ☐ Caregiver ☐ Guardian ☐ Child ☐ Grandparent ☐ Other _____

Phone Number(s):
[Home] _____
[Work] _____
[Cell] _____

Medical Information Release:

I authorize the following to access my medical information including all billing and/or insurance transactions:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Financially Responsible Party: ☐ Patient ☐ Alternate Contact

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Employment Information:

Employment Status: ☐ Full-Time ☐ Part-Time ☐ None
☐ Retired ☐ Volunteer: _____

Occupation: _____ **Employer:** _____
[If retired, prior occupation]

Employer Address: _____
[Appt / Unit No.] [Street No.] [Street]

_____
[City] [State] [Zip]

Insurance Information:

Please give your insurance information to our front office staff so we can make a copy for our records.
If the insurance is NOT under the patient name, please complete the below section.

Subscriber's Name: _____
[First] [MI] [Last]

DOB: _____
[MM / DD / YYYY]

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Guardian ☐ Other _____

Physician Information:

Primary / Family Physician: _____
[First] [MI] [Last]

PCP Address: _____
[Unit No.] [Street No.] [Street]

_____
[City] [State] [Zip]

How did you Hear about us?

☐ Physician _____	☐ Google	☐ Billboard
☐ Family / Friend _____	☐ Healthy Hearing	☐ Facebook
☐ Radio / Station _____	☐ Oticon	☐ Senior Blue Book
☐ Health Fair _____	☐ Walk-By	☐ Parents Magazine
☐ Newspaper _____	☐ Mail	☐ Portico Magazine
☐ Employer _____	☐ Insurance	☐ Mobile Bay Magazine
☐ Other _____	☐ Yellow Pages	

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Acknowledgement and Authorization	**Initial Here**

- I (the patient or parent / legal guardian) acknowledge receipt and review of the Health Insurance Portability & Accountability Act (HIPAA) policy of Naro Audiology & Hearing Solutions, LLC (NAHS).
- I certify that the demographic and insurance information provided is correct. I agree to notify NAHS of any changes in address, phone number, or insurance coverage.
- This Acknowledgement and Authorization with Assignment of benefits applies and extends to subsequent visits and appointments at NAHS.

Authorization for Treatment	**Initial Here**

- I authorize staff of Naro Audiology & Hearing Solutions LLC to administer appropriate testing and/or treatment for my (the patient) diagnosis / rehabilitation. I understand that no guarantee, or assurance, has been made as to the results that may be obtained from the services rendered.

Authorization to File Insurance and Assignment of Benefits	**Initial Here**

- I (the patient or parent / legal guardian) authorize Naro Audiology & Hearing Solutions LLC (NAHS) to file claims to the my (the patient) insurance company on my behalf for professional services or purchases provided by NAHS.
- I hereby assign all applicable medical benefits to which I am entitled to NAHS.
- I hereby authorize NAHS to release all information necessary to process my claim and any appeals for any denial of payment and/or adverse benefit determination.

NAHS Financial Policy	**Initial Here**

- I (the patient or parent / legal guardian) understand NAHS as a professional courtesy will submit my claim to my insurance provider, but this does not guarantee payment by the insurer.
- I understand and agree that, regardless of insurance status, I am ultimately financially responsible for the balance of the patient's account for professional services or purchases rendered including co-payments, co-insurance, deductibles, and non-covered professional services or purchases.
- I understand that payment for non-covered professional services or purchases is due at time of rendering.
- I agree that, as permissible by law, the patient / legal guardian will reimburse NAHS for all costs, expenses, interest, late fees, and attorney's fees that may be incurred by NAHS to collect unpaid balances.
- I understand from time-to-time, upfront payment in full will be required for professional services or purchases. If payment is made by my insurance provider, NAHS will reimburse accordingly.
- I understand NAHS strives to file claims as soon as possible, regardless if payment is collected at time of service, and within the insurance provider's timely filing limit. NAHS makes not guarantee to the timing of filing, insurer payment, and any relevant reimbursement.

Medicare Patients Only	**Initial Here**

- I request payment of authorized Medicare benefits be made payable to Naro Audiology & Hearing Solutions LLC for any services rendered.
- I authorize any holder of medical information about me to be released to the Health Care Financial Administration and its agents. Any information needed to determine these benefits or related service to pay the claim should be provided. The provider agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is only responsible for any deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determined by the Medicare carrier.

I have read and understand all the Acknowledgement and Authorization information.

Patient Signature _____ **Date** _____

Parent/ Guardian Signature _____ **Date** _____