

# REGISTRATION

## *BRC Family Hearing Solutions*

198 Unita Dr. Green River, WY 82935

(307) 875-1460 Main (307) 875-1586 Fax

### PATIENT INFORMATION

Name \_\_\_\_\_ SSN \_\_\_\_\_  
Last First Initial

List all other names used \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Sex • M • F Age \_\_\_\_\_ Birthdate \_\_\_\_\_ • Single • Married • Widowed • Separated • Divorced

Home Phone \_\_\_\_\_ Cellular Phone \_\_\_\_\_

Physical Address \_\_\_\_\_ Mailing address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

In case of an emergency who should we notify (name, relationship, phone & address)? \_\_\_\_\_

Known drug allergies \_\_\_\_\_

Primary Care Physician's Name \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

### PAYMENT POLICY

**PLEASE NOTE: All copay, coinsurance, non-covered charges and unmet deductible amounts are *DUE AND PAYABLE AT THE TIME OF SERVICE.***

**SELF PAY: *Payment is expected at the time of service. Please notify receptionist of payment method. We accept cash, checks and all major credit cards.***

### INSURANCE

#### PRIMARY INSURANCE (Billed 1<sup>st</sup>)

Insurance Co Name \_\_\_\_\_

Address \_\_\_\_\_

City, St, Zip \_\_\_\_\_

Phone \_\_\_\_\_

Member's Name \_\_\_\_\_

Address \_\_\_\_\_

City, St, Zip \_\_\_\_\_

Phone \_\_\_\_\_

SSN \_\_\_\_\_ Birthdate \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Group# \_\_\_\_\_ ID# \_\_\_\_\_

Employer Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City, St, Zip \_\_\_\_\_

#### SECONDARY INSURANCE (Billed 2<sup>nd</sup>)

Insurance Co Name \_\_\_\_\_

Address \_\_\_\_\_

City, St, Zip \_\_\_\_\_

Phone \_\_\_\_\_

Member's Name \_\_\_\_\_

Address \_\_\_\_\_

City, St, Zip \_\_\_\_\_

Phone \_\_\_\_\_

SSN \_\_\_\_\_ Birthdate \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Group# \_\_\_\_\_ ID# \_\_\_\_\_

Employer Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City, St, Zip \_\_\_\_\_

## CONFIDENTIAL COMMUNICATIONS

You have the right to request that you receive communications regarding your protected health information in a manner and/or location of your choosing. Please complete the information below to assist us in meeting your needs. **I wish to be contacted in the following manner (check all that apply):**

Home Telephone \_\_\_\_\_

- O.K. to leave detailed message
- Leave message with call-back number only

Work Telephone \_\_\_\_\_

- O.K. to leave a detailed message
- Leave message with call-back number only

Written Communication

- O.K. to mail to my home address
- O.K. to mail to my work address

Email \_\_\_\_\_

Fax \_\_\_\_\_

Other \_\_\_\_\_

## CONSENT

By signing this form, I authorize the practitioners at BRC Family Hearing Solutions provides audiological care and other such services as they may deem necessary. I understand that there are no express or implied guarantees regarding the results of any audiological testing and/or treatment provided at this clinic.

By signing this form, I acknowledge that I have read and understand the *Notice of Privacy Practices* given to me at the time of initial registration which provides detailed information about my rights and how and under what circumstances my protected health information may be used and disclosed. I understand that my health information may be used and disclosed in accordance with the *Notice of Privacy Practices* so that any treatment and/or services I receive at this clinic may be billed to and payment collected from me, an insurance company, and/or other third party.

I acknowledge that BRC Family Hearing Solutions charges a No Show/No Call fee of \$25.00 for all appointments that are not cancelled within 24 hours of the scheduled appointment time. If the appointment is rescheduled within 30 days of the missed appointment, this fee may be waived.

**I understand that I am financially responsible for payment in full for services rendered whether or not paid by insurance.** I understand that charges not paid at 120 days will start to accrue an interest rate of 18% A.P.R., and charges after 150 days will be considered for further collection action. Furthermore, by signing this form I agree to directly assign to BRC Hearing Solutions all insurance benefits, if any, otherwise payable to me for services rendered. I certify that the information I provided on this form is complete and accurate.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**