REGISTRATION

(Minor/Dependent)

BRC Family Hearing Solutions

198 Uinta Dr. Green River, WY 82935

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

PATIENT INFORMATION

Name_____ SSN_____

Last First Initial

Sex • M • F Age_____ Birthdate_____ Home Phone _____ Cell Phone _____

Address_____City_____ State_____ Zip _____

Who has legal custody (Name & Relationship)?_____

Who has consent for medical care in an emergency if we are unable to reach you (Name, Relationship, Address & Phone)?

_____

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.

MOTHER'S Name _____

Street Address_____

Mailing Address _____

City, St, Zip_____

Home Phone _____

Cell Phone _____

SSN_____ Birth date_____

Employer Name

_____

Address_____

City, St, Zip_____

Phone_____ Occupation _____

FATHER'S Name

_____

Street Address_____

Mailing Address _____

City, St, Zip_____

Home Phone _____

Cell Phone _____

SSN_____ Birth date_____

Employer Name _____

Address_____

City, St, Zip_____

Phone_____Occupation_____

NON-CUSTODIAL PARENT(S) (if applicable)

Name_____

_

Street Address_____

Mailing Address _____

City, St, Zip_____

Home Phone _____

Cell Phone _____

SSN_____ Birth date_____

Employer Name

_____

Address_____

City, St, Zip_____

Phone_____Occupation_____

PRIMARY INSURANCE (Billed 1st)

Insurance Co

Name_____

Address _____

City, St, Zip_____

Phone_____

Member's Name _____

Address _____

City, St, Zip_____

Phone

_____

SSN_____ Birth date_____

Relationship to Patient _____

Group#_____ ID#_____

Employer Name

_____

Address_____

City, St, Zip_____

Phone_____

SECONDARY INSURANCE (Billed 2nd)

Insurance Co

Name_____

Address _____

City, St, Zip_____

Phone_____

Member's Name _____

Address _____

City, St, Zip_____

Phone_____

SSN_____ Birth date_____

Relationship to Patient _____

Group#_____ ID#_____

Employer Name _____

Address_____

City, St, Zip_____

Phone_____

--CONTINUED ON BACK--

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 detailed message
  - Leave message with call-back number only
- Cell Phone_____
  - O.K. to leave 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 to provide 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 Family 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**