

## REGISTRATION

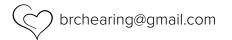
PATIENT INFORMATION								
Name					SSN			
	Last	First		Initial				
List all other names used				Spouse's Name				
Sex □ M □ F	Age	Birthdate		Single	ed 🗆 Widowed	☐ Separated	☐ Divorced	
Home Phone _				Cellular Phone				
Physical Addres	SS			Mailing Address				
City		State	Zip	City	Stat	te Zi	p	
Employer				Occupation				
Business Addre	ess			Business Phone				
In case of an er	mergency, w	hom should we noti	fy (name, relat	tionship, phone & address)?				
Primary Care Pl	nysician's Na	ame						
Whom may we	thank for ref	ferring you?						
How did you he	ear about us	?						
			ΡΔΥΙ	MENT POLICY				

**INSURANCE** 

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.

## **PRIMARY INSURANCE** (Billed 1st) **SECONDARY INSURANCE** (Billed 2<sup>nd</sup>) Insurance Co. Name\_\_\_ Insurance Co. Name\_\_\_\_ Address Address City, St., Zip \_\_\_ City, St., Zip \_\_\_ Member's Name Member's Name \_\_\_\_\_ Address City, St., Zip \_\_\_\_ City, St., Zip \_\_\_\_\_ Birthdate \_\_\_\_\_ \_\_\_\_\_Birthdate \_\_\_\_\_ Relationship to Patient Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ \_\_\_\_\_ Birthdate \_\_\_\_\_ Group# \_\_\_ Employer Name Employer Name Address \_\_ Address \_\_\_ Phone \_\_\_ 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
ocation 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):

the foll	owing manner (check all that apply):	
•	Home Telephone	
	OK to leave detailed message	
	Leave message with callback number only	
•	Work Telephone	
	OK to leave detailed message	
	Leave message with callback number only	
•	Written Communication	
	OK to mail to my home address	
	OK to mail to my work address	
•	Email	
•	Fax	
•	Other	
	CONSENT	
By sign initial re health with the	diological testing or treatment provided at this clinic.  Ining this form, I acknowledge that I have read and understand the <i>Notice of Pri</i> Registration, which provides detailed information about my rights and how and information may be used and disclosed. I understand that my health information in the <i>Notice of Privacy Practices</i> so that any treatment or services I receive at this e, an insurance company or other third-party.  Rewledge that BRC Family Hearing Solutions charges a No-Show/No-Call fee of	under what circumstances my protected on may be used and disclosed in accordance clinic may be billed to and payment collected
cancel	ed within 24 hours of the scheduled appointment time. If the appointment is retment, this fee may be waived.	
I under will be Solutio	stand that I am financially responsible for payment in full for services rendered stand that charges not paid at 120 days will start to accrue an interest rate of 1 considered for further collection action. Furthermore, by signing this form, I agons all insurance benefits, if any, otherwise payable to me for services rendered form is complete and accurate.	8% A.P.R., and charges after 150 days gree to directly assign to BRC Family Hearing
SIGNA		 DATE