Beverly Hills Hearing Center

PATIENT REGISTRATION

Last Name: _____ First Name: _____ MI: ____

Address: _____
Street Apt # City State Zip

Date of Birth: ____ /____ /____ Marital Status: S M W D Sex: M F

SS #: _____ Home Phone: _____ Cell Phone: _____

Email Address: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ #:_____ Relationship: _____

ENT or Primary Physician: _____ _ Referred by (if different): _____

Check box if you would not like to receive promotional emails regarding latest hearing aid technology

Primary Insurance: _____ Insurance ID#: _____

Name of Policy Holder _____ Policy Holder's DOB: _____

Secondary Insurance: _____ Insurance ID#: _____

I authorize Beverly Hills Hearing Center to release my information requested with regard to processing claims to insurance. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. A service fee of 1.5% per month (18% per annum) will be charged on the unpaid principal balance on all accounts not paid within 60 days of date of service.

I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Beverly Hills Hearing Center of any changes in my health status or in the above information.

Signature_____ Date _____

Parent Signature if Minor _____ Date _____

Last Name	First Name	M.I.

MEDICAL HISTORY ABOUT YOUR EARS

Have you seen an ear doctor within the last 6 months?	Y	N
Have you had your hearing tested recently? If yes, when? _____	Y	N
Do you think you have hearing loss?	Y	N
Did your hearing loss progress gradually?	Y	N
Do you have better hearing in your right or left ear? _____	Y	N
Do other members of your family have hearing problems?	Y	N
Have you ever worn a hearing aid? If yes, how long? _____	Y	N
Do you have ringing or noises in your ears? Right, left or both? _____	Y	N
Do you have vertigo, dizzy spells, or nausea?	Y	N
Do you currently have fullness or a plugged sensation?	Y	N
Have you had recent earaches, ear infections or discharge?	Y	N
Do you have a history of exposure to high levels of noise?	Y	N
Have you ever had ear surgery?	Y	N
Are you currently using blood thinners?	Y	N
Do you have any major illnesses and/or infectious diseases?	Y	N

Beverly Hills Hearing Center
9100 Wilshire Blvd. Suite 310 E
Beverly Hills, Ca. 90212
P. 310-276-8585 F. 310-276-2045

PATIENT CONSENT FOR SERVICES: I hereby consent to and authorize the performance of all treatments, and medical services by the staff of Beverly Hills Hearing Center.

FINANCIAL RESPONSIBILITY FOR SERVICES: I hereby authorize my insurance benefits be paid directly to Beverly Hills Hearing Center. I understand that I may have financial responsibility for all or a portion of the charges for the professional services rendered and will remit appropriate payment at the time of service, including specifically co-payments and charges for services which are not covered by my insurance.

COPAYMENT POLICY: If applicable, at the time of check in, I will be required to pay a co-payment, if I do not pay my co-payment; I understand that my visit may be cancelled.

INSURANCE COVERAGE: I acknowledge that it is my responsibility to understand the benefits and limitations on benefits under my insurance or health plan and to contact my insurance carrier/health plan if I have questions.

REFERRAL/AUTHORIZATION: I understand that depending on my insurance, I may need a referral from my provider to see a specialist. If so, and my provider decides it is medically necessary, I will allow 7-10 working days for this process. I will be promptly advised of any requests that are determined not to be appropriate or necessary. I understand that if I choose to access specialty services without prior authorization from my provider I may be financially responsible for the services rendered and insurance may not cover the relevant services.

RELEASE OF INFORMATION: I authorize the release of my medical records or other information necessary to provide health care, to process my medical claims, and for other purposes relating to the health care operations. Additional information is provided in our Notice Of Privacy Practices.

FEES FOR PATIENT'S HEALTH INFORMATION: I hereby understand that I may be charged a cost-based fee when requesting copies of my health information, including the cost of copying (supplies and labor), postage (if information is to be mailed), and preparation for any summary or explanation if agreed to in advance.

Patient Name: _____ **Date:** _____

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

By checking this box and signing below, I acknowledge that I received a copy or Beverly Hills Hearing Center's notice of privacy practices. The notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full notice. I understand that a copy of the current notice will be posted in the reception area, the website (if applicable) and that any revised notice of privacy practices will be made available.

_____ _____

Printed name of patient or personal representative Date

_____ _____

Signature of patient or personal representative Date