New Patient Form

Welcome to Audiology Services of West Virginia! We strive to do our best to help you reconnect to your world and communicate with your friends and loved ones through hearing. Please fill out this form completely. If you have questions, please ask our Patient Care Coordinator!

PATIENT INFORMATION

Today's Date: _____

☐ Ms. ☐ Mrs. ☐ Mr. ☐ Dr. ☐ Rev

I prefer to be called: _____

First Name: _____ Last: _____ MI: ___

DOB: ____ /____ /____ ☐ Male ☐ Female

SSN: _____-____-_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address: _____

_____

CITY STATE ZIP

Preferred Phone #: _____ (Home/Cell/Work)

Other Phone #: _____ (Home/Cell/Work)

Email Address: _____

Preferred Contact Method (circle one): Email Cell# Wk# Hm#

Best times to reach you? _____

Employer:_____

Primary Care Physician: _____

Other family members seen by us?_____

SPOUSE/PARENT INFORMATION

His/Her Name: _____

Relationship to Patient: _____

DOB: ____/____/_____ Best Phone #: _____

Person Responsible for Account: _____

Guarantor DOB: _____

Billing Address: _____

Relation: _____ Phone: _____

EMERGENCY CONTACT

Name: _____

Relation: _____

Preferred Phone #: _(___)_____

Other Phone #: _(___)_____

REFERRAL INFORMATION

We like to know how our patients found us! Please mark all that apply

☐ Physician	☐ Friend / Co-worker	☐ Facebook Page
☐ Audiologist	☐ Health Plan / HMO	☐ Twitter
☐ Internet	☐ Family Member	☐ TV Commercial
☐ Voc. Rehab.	☐ Hospital Referral	
☐ Yellow Pages	☐ Our Website	

☐ Other: _____

☐ Name of Person Who Referred You: _____

❖ **What are your goals for today's appointment?**

_____

_____

_____

_____

_____

❖ **Do you have any questions for your provider?**

_____

_____

_____

_____

_____

Acknowledgement of Receipt of Notice of Privacy Practices

This company's Notice of Privacy Practices may be found online at www.hearwv.com or in hard copy.

I attest that I have been given the opportunity to receive a copy of this office's Privacy Practices or have been directed to a copy of these practices that may be accessed either in hardcopy or electronic copy. Please notify the office's Patient Care Coordinator if you would like a printed copy of Privacy Practices.

_____ _____

Signature Date

Patient Financial Agreement

•As a courtesy, we will be happy to bill your current insurance and co-insurance for services; **however, all charges, regardless of insurance of insurance coverage are the patient's responsibility.** Our clinic contracts with most insurance companies. It is your responsibility to contact your insurance company prior to services to investigate in-network eligibility. Signing this document gives us permission to bill your insurance company for services you receive.

•It is important to remember that your individual contract with your insurance company determines co-pays, deductibles, etc. and how your insurance will pay for covered services. We make every effort to bill each visit with the proper diagnosis and procedure codes per national billing and coding guidelines as well as requirements for each insurance company. **Please understand that we cannot make exceptions to our coding practices due to federal and state legal compliance concerns, and we are unable to bill for services other than those documented in your medical records in our clinic.**

•Health insurance is required prior to services being rendered. If no health insurance information is provided at the time of service, you may be denied services until your insurance information can be documented or you may opt to pay out-of-pocket for services. **It is your responsibility to ensure that insurance information is up-to-date and in effect. If Insurance information provided to our clinic at the time of service is, at any time, found to be incorrect or not in effect, you will be billed for any services provided.**

•You may opt at any time to pay out-of-pocket rates for services that are typically billed to insurance. Charges for services not covered by insurance are due at the time of service. If you have a question if services are covered or not please ask prior to the administration of the service.

I have read and understand the above information and agree to comply with these policies.

_____ _____

Print Name Date

_____

Signature

Out- of -Pocket Rates for Services

- **Audiological Evaluation- $100**
- **Hearing Screening-$50**
- **All Vestibular Services-$150/hr**
- **TruHearing/ EPIC Office Visit-$65**

***NOTE: Services not typically covered be insurance will not be billed at these rates.**

- It is important to strictly enforce this policy of financial obligation. **All co-pay, self-pay, and other payments are due at the time of service and may be paid by cash, check, credit, or debit card. We also offer financing through several institutions. Please ask for more information about financing.**

- Fees may be assessed for no-shows and cancellation of appointments without 24 hours prior notice for any office visit. **These fees are the responsibility of the patient and cannot be filed with your insurance company. Cancellation messages may be left on the company answering machine for your convenience but must be 24 hours in advance of scheduled appointment time to avoid fees.**

No Show/ Cancellation Fees

- Cancellation without prior notice- $25
- 1st No Show- $25
- 2nd No Show-$50
- 3rd No Show-$75

- All charges are due within 30 days of invoive date. Second notices will be sent if not paid on due date. **All charges not paid within 90 days will be processed by our collections agency.**

Thank you for completely filling out this form for us today. It will allow us to more effectively help you to make decisions about your hearing healthcare. If you have any questions, at any time, please feel free to ask! We are happy to help.

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