HEAR Center
301 East Del Mar Boulevard, Pasadena, CA 91101
Phone: (626) 796-2016 Fax: (626) 796-2320
www.hearcenter.org

Payment is due at time of service. How are you paying for services today?
□Cash □Check □Visa/MC □CCS □Medi-Cal □Medicare □Regional Center □HMO □PPO

Patients name _____ Date of Birth_____

Child Lives with: □Mother □Father □Both Parents □Other, _____

Mother's Name (or Legal Guardian)_____
Address (If different from patient's) _____
Email _____
Occupation _____ Work # _____Alternate # _____

Father's Name (or Legal Guardian)_____
Address (If different from patient's) _____
Email _____
Occupation _____ Work # _____Alternate # _____

Emergency Contact Name _____Relationship _____
Address _____ City _____ State_____ Zip_____
Phone _____

Please answer the following questions to the best of your knowledge.

Have you observed a hearing loss? □No □Yes, explain _____

Does child respond to soft sounds? □No □Yes **If No**, explain_____

Did child have a Newborn Hearing Screening when born? □No □ Yes **Passed screening** □Yes **Failed Screening**

Ear Surgery? □No □Yes, explain _____

Meningitis? □No □Yes, explain _____

Head Injuries? □No □Yes, explain _____

Ototoxic Drugs (drugs that may cause hearing problems)? □No □Yes, explain _____

Seizures? □No □Yes, explain_____

Medical Condition(s)/Syndromes? □No □Yes, explain _____

Did mother have German measles during pregnancy? □No □Yes When? _____

Premature birth? □No □ Yes How many weeks early? _____ Complications: _____

Anoxia (not enough oxygen during birth)? □No □Yes, explain _____

Wears hearing aids? □No □Yes At what age? _____Where fitted with aids? _____

Family history of hearing loss **(before age 40)?** □No □Yes Relationship _____

Answer the following questions if your child is 10 years or younger

Age child sat up _____ Age walked _____

Is child's coordination good?	□No	□Yes
Is child's vision good?	□No	□Yes
Is child's language normal for age?	□No	□Yes
Does child babble?	□No	□Yes
Does child gesture instead of voice?	□No	□Yes
Does child understand speech?	□No	□Yes
Does child have unclear speech?	□No	□Yes

Release of information (to physician, school, and other agencies working with child)

I hereby authorize HEAR Center to release information. The authority extends to the furnishing of copies of all desired parts of these records. The question of privacy between the HEAR Center, the attending physician(s) and patient is waived.

Signature: _____ Date: _____

Information on this form is confidential and released ONLY with your consent.

Thank you for choosing HEAR Center for your child's hearing and speech and language needs.

Did you know that HEAR Center is a 501(c)(3) non-profit agency? **We provide free hearing and speech screenings for children and seniors** in our community every week. You can help us continue this important public service by donating just $5, $10, or $20. See the front desk for details!

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PATIENT INFORMATION

{Please Print}

Last Name:_____ First Name:_____

Address:_____ Apt.#:_____

City:_____ State:_____ Zip Code:_____

Home phone#: ( )_____ Work phone#: ( )_____

Cell Phone #: ( )_____ E-Mail _____

Date of Birth:_____ Age:_____ Sex:_____

Social Security#:_____ Driver's License#:_____

Ethnicity: ☐ Asian ☐ Black/African Amer. ☐ Amer. Indian/Alaska Native ☐ Latin/Hispanic
☐ Pacific Islander ☐ White/Caucasian ☐ Other

How Did You Hear About Us? Please indicate from choices below.

☐ Pasadena Star Newspaper ☐ Pasadena Senior Center Magazine ☐ YELP ☐ Online Search
☐ Senior Center _____ ☐ Friend _____ ☐ Client _____ ☐ Other _____

What is the name of the Physician that referred you HEAR Center?_____

RESPONSIBLE PARTY

Last Name:_____ First Name:_____

Relationship to patient:_____

Address:_____ Apt.#:_____

City:_____ State:_____ Zip Code:_____

Home phone#: ( )_____ Work phone#:( )_____

E-Mail home:_____ E-Mail Work:_____

Date of Birth:_____ Age:_____ Sex:_____

Social Security#:_____ Driver's License#:_____

INSURANCE INFORMATION

Insured Name:_____ Date of Birth:_____

Insurance company name:_____ Subscriber:_____

Complete Insurance Address:_____

Policy/Group#:_____ Employer:_____

Check one: ☐ HMO ☐ PPO ☐ Medicare ☐ Medi-cal ☐ other_____

SECONDARY INSURANCE (MEDICARE PATIENTS ONLY)

Check one: ☐ Supplemental or ☐ Retirement Plan

Insured Name:_____ Date of Birth:_____

Insurance company name:_____ Subscriber:_____

Complete Insurance Address:_____

Policy/Group#:_____ Employer:_____

Check one: ☐ HMO ☐ PPO ☐ Medicare ☐ Medi-cal ☐ other_____

I hereby assign to HEAR Center all monies to which I am entitled for charges(s) related to the service(s) provided. I understand that I am financially responsible to HEAR Center for charges not covered by this assignment. Also, I authorize the release of any information in order to process claims.

Signature:_____ Date:_____

Who do you authorize to receive copies of records?
Please complete one section for each physician, facility, or for yourself.

I, the undersigned, hereby authorize HEAR Center to provide medical information or records to:

Person or Physician:_________________________ Phone:_______________

Address:____ Apt.#___________

City:_______________________ State:__________ Zip code:_____________

Signature of representative to patient:_________________________________

I, the undersigned, hereby authorize HEAR Center to provide medical information or records to:

Person or Physician:_________________________ Phone:_______________

Address:____ Apt.#___________

City:_______________________ State:__________ Zip code:_____________

Signature of representative to patient:_________________________________

I, the undersigned, hereby authorize HEAR Center to provide medical information or records to:

Person or Physician:_________________________ Phone:_______________

Address:____ Apt.#___________

City:_______________________ State:__________ Zip code:_____________

Signature of representative to patient:_________________________________

I, the undersigned, hereby authorize HEAR Center to provide medical information or records to:

Person or Physician:_________________________ Phone:_______________

Address:____ Apt.#___________

City:_______________________ State:__________ Zip code:_____________

Signature of representative to patient:_________________________________

CONSENT TO RELEASE MEDICAL HISTORY

_____ _____

Patient Name: Date of Birth:

_____ _____

City: State:

_____

Date:

To Whom it May Concern:

This authorizes all physicians, hospitals, and medical attendants to furnish any and all medical records, history and information to HEAR Center, or to any representative of HEAR Center, concerning my medical condition. This authorization also includes examination of all hospital records, x-ray film, and furnishing of any information including opinions. You are further requested not to disclose such information to any other person without written authority to do so.

_____

Patient / Parent / Legal Guardian

FINANCIAL POLICY
STATEMENT OF FINANCIAL RESPONSIBILITY

Thank you for using HEAR Center as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. All patients must read and sign this policy before being seen.

ALL COPAY AND DEDUCTIBLE MONIES ARE DUE AT TIME OF SERVICE
WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD AND AMERICAN EXPRESS

REGARDING INSURANCE

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. All charges incurred are the responsibility of the patient or their guarantor. We will bill your insurance company as a courtesy. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. If your insurance company has not paid your account within 60 days the balance will automatically be billed to you. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Benefit inquiries and authorizations are not a guarantee of payment by your insurance company.

OVERPAYMENT

Our policy is to collect a payment of 50% of charges at the time of service for non provider insured patients, unless other arrangements have been made. If you feel you have overpaid please feel free to contact our billing department so we can research and process any refunds due to you. All refunds are processed in the same manner as payment was received. If any credits on your account are due to insurance overpayments a refund will be made to the insurance company.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Prearranged contract rates will be honored.

MINOR PATIENTS

The adults accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, MasterCard or American Express, or payment by cash or check at time service has been provided.

MISSED APPOINTMENTS

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments fee of $40 for Speech Therapy and $25 for Audiological Evaluations. Please help us serve you better by keeping scheduled appointments.

INTEREST

We reserve the right to charge interest in the amount of 10% as provided by state law.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy:

_____
Name Printed

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Signature of Co-Responsible Party Date

NOTICE OF PRIVACY PRACTICES
Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices*** of

HEAR CENTER

Our ***Notice of Privacy Practices*** provides information about how we may use and disclose your protected health information. We encourage you to read in full.

Our ***Notice of Privacy Practices*** is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting HEAR Center at (626)796-2016.

I acknowledge receipt of the ***Notice of Privacy Practices*** of **HEAR Center**

Signature: _____ Date: _____
Parent/patient/conservator/guardian

Print patient Name: _____

FOR OFFICE USE ONLY

INABILITY TO OBTAIN AKCNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement and the reason why the acknowledgment was not obtained.

Signature of provider representative: _____ Date: _____

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other (Please Specify) _____