

**Olympic Hearing Center**  
538 North 5<sup>th</sup> Ave, Sequim, WA 98382 360-681-7500

**PATIENT REGISTRATION**

Confidential

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parents' name (if patient is under 18 years) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Which phone number would you prefer we use? \_\_\_\_\_

Email: \_\_\_\_\_ (will not be given to anyone outside of this office)

We confirm appointments. Do you prefer to be called or sent an e-mail? \_\_\_\_\_

Are you (Please circle):    Male    Female

Are you (Please circle):    Married    Single    Widowed    Other: \_\_\_\_\_

Are You:    Employed:    Full time    Part time    Retired    Unemployed

Student:    Full time    Part time    Name of school \_\_\_\_\_

**INSURANCE INFORMATION** (Please provide your insurance card/cards to copy)

Subscriber's name: \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_

Insured's relationship to subscriber: \_\_\_\_\_ ID and Group #: \_\_\_\_\_

Subscriber's place of employment: \_\_\_\_\_

Subscriber's address (if different from Patient): \_\_\_\_\_

***Secondary insurance***

Subscriber's name: \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_

Insured's relationship to subscriber: \_\_\_\_\_

Subscriber's place of employment: \_\_\_\_\_

Subscriber's address (if different from Patient): \_\_\_\_\_

**(ID CHECK \_\_\_\_\_)**

# Olympic Hearing Center

Name: \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

We keep a record of the health care services we provide you. You may ask to see that record. You may also ask to correct that record. You may review your record or obtain more information about the record by contacting the office. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you can access your information. This is available by request.

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

\_\_\_\_\_ (Initials) I hereby acknowledge receipt of the Notice of Privacy Practices.

## AUTHORIZATIONS:

May we leave message on your Home Answering Machine? yes \_\_\_ no \_\_\_

On your Cell Phone Voice Mail? yes \_\_\_ no \_\_\_

May we send mail to you? yes \_\_\_ no \_\_\_

Is there someone you authorize us to share your information with (such as leaving a message, scheduling appointments, information about your visits here)?

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

DOB: \_\_\_\_\_ (for ID purposes only).

Phone # \_\_\_\_\_ (if different from patient)

May we send reports to your doctor (provider)? yes no

Name of Provider: \_\_\_\_\_

## AUTHORIZATION TO TREAT:

I hereby authorize Olympic Hearing Center to examine and treat myself or my minor child. I am aware that the practice of Audiology is not an exact science and I acknowledge that no guarantees or promises have been made as to the result of such examination or treatment.

## FINANCIAL AGREEMENT: (initial)

\_\_\_\_\_ **Assignment of Insurance Benefits:** I authorize my insurance benefits to be paid directly to the provider of services. I authorize the release of any medical or other information necessary to process the claim. If my insurance company determines that a particular service is not covered, reasonable or necessary, including but not limited to hearing testing and hearing aids, I agree to pay for Non-Covered Services, as determined by my insurance company. I will be personally responsible for this account. If delinquent, I agree to pay any interest or collection fees which may accrue.

\_\_\_\_\_ **Self-Pay Financial Agreement:** I am currently not covered by an insurance plan and will personally be responsible for payment for services to me at Olympic Hearing Center. If delinquent, I agree to pay interest or collection fee which may accrue. I understand that I may request a payment plan.

## **Signature of Patient, Guardian, or Authorized Representative:**

\_\_\_\_\_ Date \_\_\_\_\_