PATIENT DEMOGRAPHIC FORM

Patient Information:

Name:

Mr./Mrs./Ms./Miss: _____
First Last Middle

Address: _____ City: _____ State: _____ ZIP: _____

Day Phone: _____ Other Phone: _____ Mobile Phone: _____

Gender: ○ M ○ F Date of Birth: _____ Social Security#: _____ (optional)

Marital Status: ○ Single ○ Married ○ Other

Employment Status: ○ Employed ○ Retired ○ Student: (circle one) FT / PT ○ Other

Companion Name: _____ Phone: _____

Email: _____ Fax#: _____

Family Doctor: _____ Phone: _____

Referring Physician: _____ Phone: _____

Would you like your results sent to your family doctor? **Y / N** (circle one)

Marketing: How did you hear about our clinic?

○ Direct Mail ○ Internet ○ Radio
○ Newspaper ○ Magazine ○ Signage
○ Television ○ HearPO ○ Grassroots
○ Physican Referral ○ Managed Care ○ Yellow Pages
○ Friend/Patient Referral ○ Continuous care ○ Other: _____

Guarantor Information (if patient is a minor):

Parent/Legal Guardian (Guarantor): _____ Social Security#: _____

Address: _____ City: _____ State: _____ ZIP: _____

Day Phone: _____ Other Phone: _____ Mobile Phone: _____

Please complete inside.

5882 Bolsa Ave., Ste.130,Huntington Beach CA 92649
www.sonushearing.com

Insurance Information; please provide Insurance card(s) with this completed form:

Policy Holder's Name:_____ Policy Holder's Date of Birth: _____

Address:_____ City: _____ State: _____ ZIP:_____

Day Phone: _____ Social Security#: _____

Insurance Company: _____ Insured's ID#:_____

Insured's Policy Group:_____ Policy Holders Relationship: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name/Program: _____

Do you have Medicare Coverage? ○ Yes ○ No

Policy Holder's Employer Name: _____ Phone: _____

Secondary Insurance Information:

Policy Holder's Name:_____ Policy Holder's Date of Birth:_____

Address:_____ City: _____ State: _____ ZIP:_____

Day Phone: _____ Social Security#: _____

Insurance Company: _____ Insured's ID#:_____

Insured's Policy Group:_____ Policy Holders Relationship: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name/Program: _____

Do you have Medicare Coverage? ○ Yes ○ No

Policy Holder's Employer Name: _____ Phone: _____

Additional Insurance Information:

Please use additional form to record supplementary insurance.

Workers Compensation Information:

Worker's Comp Company Name:_____ Adjustor's Name:_____

Claim Number:_____ Date of Injury: _____

Employer's Name: _____

Preferences:

Language: _____

Special Needs: _____

Best time of day to contact you: _____

Please complete other side.

Financial Agreement:

We participate in many different insurance plans. We will file your insurance claims for the companies with whom we are contracted. You will be responsible for any co-payments or deductibles at the time services are rendered. For some insurance we accept assignment of benefits but in all cases we require that the guarantor, the person who is financially responsible, is personally liable for all balances not covered by insurance. It is our responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance companies. You will be responsible for co-payment, deductibles, out-of-network amounts or any portion your insurance company indicates is your responsibility. Payment for co-pays are expected at the time of service. If this fee is not covered by insurance it will be your responsibility. We allow your insurance company 45 days to pay your claim. If we do not receive payment in 45 days, you will be given a bill at that time. For our HMO/PPO patients, if we are contracted with your HMO/PPO, you will not receive a bill until we have heard from your insurance company.

Assignment of Insurance Benefits:

I hereby authorize direct payment to Sonus of any insurance or health benefits otherwise payable to or on behalf of the patient for examination, treatment or devices delivered to me by Sonus, at the rate not to exceed Sonus' usual charges. I understand that verification of insurance coverage obtained over the phone or online is estimated and does not guarantee payment and that insurance coverage is a relationship between the patient and his or her insurance company(s). I agree to accept financial responsibility for any charges for goods and services rendered to the patient that are not paid by insurance or health benefit plan pursuant to this assignment of benefits. I have been informed that Medicare does not provide payment for hearing aids, other assistive listening devices or fitting examinations.

Release of Information:

I hereby authorize Sonus to release any medical information about the patient necessary to determine liability for payment and to process any claim for examination, treatment or devices received by the patient. I also authorize Sonus to release the medical records of the patient to the patient's referring physician or family physician indicated on the first page of this form.

Financial Responsibility Agreement by Other than Patient's Legal Representative:

I agree to accept financial responsibility for the good and services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Benefit, and Release of Information provisions above.

I have read and agree to the terms above and on the reverse side of this form.

_____

Signature of Patient or Legal Representative | Date

_____

Signature of Insurance Policy Holder | Date

_____

Relationship to Patient | Witness (Sonus)