BEST HEARING

San Diego

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Email: OfficeAdmin@BestHearingSanDiego.com

Patient Information

Patient's Name _____ Date _____ Age _____

Date of Birth _____ Grade _____ School _____

Street Address _____ City _____ State_____ Zip_____

(if patient is a minor) Mother's Name:_____ Father's Name:___

Home Ph#_____ Work Ph#_____ Cell Ph#:_____

Preferred Email _____Occupation _____

Where did you hear about us? *This information helps us know who we can say Thank You to for sending you to us*
□ School District □ Newspaper □ Website □ Internet search □ Mailer/Letter
□ Family member □ Physician referral □ Dr. Best Patient □ School:_____
□ Friend _____ □ Saw Dr. Best at a seminar □ Other:_____

Name of person who referred you:_____

I give my consent for BHSD (Best Hearing San Diego, a division of Balance & Hearing Specialty Group, Inc.) to furnish medical care and treatment considered necessary and proper in diagnosing and/or treating my condition. **I authorize BHSD to release and/or send medical information regarding my case to other consulting and/or referring physicians**.
Name of Person(s) you wish to receive reports regarding your visit:

_____ FAX:_____Initial: _____

_____ FAX:_____Initial: _____

I understand that BHSD does not accept insurance assignment; however as a courtesy, at my request, you will mail me a detailed invoice including applicable billing codes (where available) suitable for me to forward to my insurance provider for reimbursement of my PPO out of network benefits. Most insurance providers will have some benefits for services provided by BHSD, however reimbursement from insurance carriers will vary based on individual type of coverage. Any questions regarding reimbursement from my insurance provider should be addressed to my insurance carrier directly. I understand pre-authorizations and/or quotes from my insurance provider regarding estimates of benefits available are not a guarantee of coverage or payments amounts.

BHSD requests payment is made for all services at the conclusion of your visit unless other arrangements have been made prior to services being rendered. *A fee of $45.00 will be charged for all returned checks. As a courtesy to other patients waiting to be seen by the Audiologist please contact our office with 48 hour advance notice if you are unable to keep your appointment. A fee of $100.00 will be charged for all appointments not cancelled with at least 24 hour advance notification.*

How will you pay for your visit today? Cash___ Check____ Credit Card_____ Installment Plan:_____
If other, please specify:_____
I have read and understand the above information;

X X

Signature of patient or patient's representative Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INORMAITON.

This practice is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information.

I understand that as part of my healthcare, BHSD originates and maintains health records describing my health history, symptoms, examinations, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as quality and reviewing the competence of healthcare professionals

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare. I have a right to receive a copy of the authorization upon request. I understand that I may revoke this consent in writing, except to the extent that BHSD has already taken action in reliance thereon.
I understand this authorization expires one year from the date this form is signed.
I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
I give permission to BHSD to leave a message on my answering machine and/or voice mail. Therefore, I consent to the use and disclosure of my healthcare information.
I request the following restrictions to the use or disclosure of my health information:

_____

_____

I understand the Privacy notice and understand my rights contained in the notice.
Check one - ☐Accepted ☐ Denied

X_____ X_____

Signature of Patient or Legal Representative Witness

X_____

Date