www.TheHearingDocs.com

St. George, UT
617 E Riverside Dr #102, 435.688.8866
St. George, UT
1490 E Foremaster Dr #140, 435.656.5277
Hurricane, UT
52 S 850 W #103, 435.635.3689
Mesquite, NV
330 N Sandhill Blvd #F1, 702.346.4622
Overton, NV
475 N. Moapa Valley Blvd, 702.397.8555

Cedar City, UT
1870 N Main Street #202, 435.867.0714
Beaver, UT
1109 N 100 West, 435.438.6008
Fillmore, UT
374 S Hwy 99, 435.743.6323
Delta, UT
126 S White Sage Ave, 435.864.5995
Panguitch, UT
224 N 400 East, 435.676.8303

Kimball B. Forbes, MCD, FAAA
Lance F. Greer, Au.D, FAAA
Eric L. Maxwell, Au.D., FAAA
Krystal Arnold, Au.D., CCC-A
Heather Smith, Au.D., FAAA

PATIENT INFORMATION:

Today's Date:__________________

Patient Name: (Last)________________________________ (First)___________________________ (Middle initial)__________

Physical Address:____City:__________________State:_____ Zip:___________

Mailing Address:____City:__________________State:_____ Zip:___________

Home Phone: ______________________ Cell Phone: _______________________ Work Phone: ______________________

Email Address: ____ Employer: ___________________________________

Date of Birth: ______________________ Age: _______ Sex: M F Social Security Number: ________-______-_________

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other ___________________

Spouse Name (if applicable): ____ Phone #: __________________________

Race: ☐ American Indian ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ White/Caucasian

☐ Native Hawaiian/Pacific Islander ☐ Other:______________

Emergency Contact: _____________________________ Phone #: ____________________ Relationship:______________

Primary Care Physician: __________________________________ Physician Phone#: ________________________________

Referring Physician: _____________________________________ Referring Physician Phone #: ________________________

How did you hear about us? ☐ Mail ☐ Newspaper ☐ Yellow Pages ☐ Health Fair ☐ Website ☐ Employer ☐ Internet

Friend: ______________________________ Physician: _________________________ Other: ________________________

RESPONSIBLE PARTY INFORMATION:

Name of Insured: If same as above, please check here ☐

Name:____ Relationship to patient_________________________________

Mailing Address:____City:__________________State:_____ Zip:___________

Home Phone: ____________________ Cell Phone: _________________ SS# _____-____-_____ Birthdate _______________

Employer:____ Work Phone: ____

INSURANCE INFORMATION:

Primary Insurance: ____ Phone# ______________________________________

Claims mailing address: ____

Policy or Member ID#: _____________________________________ Group Number: ___________________________________

Secondary Insurance: ____ Phone# _____________________________________

Claims mailing address: ____

Policy or Member ID#: _____________________________________ Group Number: ___________________________________

Please note: AHBS Offices follow HIPPA guidelines and keeps all of your information private. No information is shared with any other party, except your personal Insurance company or whomever you authorize on your HIPPA privacy form.

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CANCELLATION POLICY: If you cancel your appointment within 24 hours, there is a $50 non-refundable charge.

*********** **PLEASE READ CAREFULLY AND SIGN BELOW** ***********

ADVANCED HEARING & BALANCE SPECIALISTS OFFICES
FINANCIAL AGREEMENT

It is your responsibility to call your Insurance Company to determine benefits, eligibility, and coverage before coming to our office. We are happy to assist you with any questions you may have, but each patient or responsible party is expected to know their own Insurance coverage, rules and benefits. It is your responsibility to provide AHBS correct/updated insurance information and that this office will bill your insurance as a courtesy to you. However, regardless of insurance coverage, you understand and agree that it is and shall remain your responsibility to pay all amounts owing as set forth herein.

________(initial) I understand that consultations for certain diagnostic testing procedures and treatments, including but not limited to; VNG, ABR, ECOG, VEMP, Cochlear related programming / adjustments and Central Auditory Processing testing may require additional payment, besides your co-pay (if applicable). These services may be applied to your deductible or co-insurance by your Insurance Company.

I understand that payment of services are due at the time of service. For those with insurance, co-pay and/or deductible amounts will need to be paid at the time of service. We will assist you in billing your insurance, however, if your insurance company has not paid and/or processed your claim within 90 days (3 months), the balance may become your responsibility and payable in full by you at that time. It will then be your responsibility to follow up with your insurance company. We will promptly reimburse you any overpayment amount you have paid when we receive payment from your insurance company. I understand that I am ultimately responsible for payment of charges for all services.

I, hereby assign, and authorize payment of Insurance benefits directly to Advanced Hearing & Balance Specialists (All service area offices) and/or Southern Utah Ear, Nose and Throat (St. George office). I personally guarantee payment of all charges incurred on my behalf and understand I am financially responsible for any amount remaining after Insurance payments and adjustments. A denial from My Insurance Company does not release me from my financial obligations, although our office will assist you the best we can to resolve the processing of the claim. However, I also understand that I am ultimately responsible for providing payment if my Insurance does not pay.

If this account is sent to collections:

1. Terms: Net 30 days from the date of invoice unless otherwise indicated above. A FINANCE CHARGE of 1 1/2% per month (annual percentage rate of 18%) of the unpaid balance will be added monthly. Should collection become necessary by legal suit or by other means, the customer agrees to pay all cost of collection including agency fee of up to 40% of the balance assigned, with or without suit as allowed by Utah Code Annotated, sec. 12-1-11.

By signing below, I agree to pay all amounts owed within 30 days of receiving a statement of when such amounts are incurred. We acknowledge that AHBS and/or SUENT Offices, including its attorneys and assigns, may have a legitimate business purpose in calling me to discuss this account and we expressly consent that we may be contacted at any telephone number listed in my patient account or any other listed means. The terms of this paragraph shall apply to all amounts incurred by me or by any individual for whom I have legal responsibility whether such amounts are incurred today or after today.

I have read this agreement and understand its terms. A photo or scanned copy or facsimile of this document shall have same legal effect as the original.

Patient / Responsible Party Signature: ____ Date: ____________________________