

Chicago Hearing Services
5600 West Addison Street
Chicago, IL 60634
(773) 685-9202

Patient Information

Patient's Name _____

First

Initial

Last

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell _____ Email _____

Date of Birth _____ Sex M ___ F ___ Social Security # _____

Marital Status Married ___ Single ___ Widowed ___ Other ___ Employment Status Full Time ___ Part Time ___ None ___

How did you hear of us? _____ Can we send you information? ___ Yes ___ No

Referring Physician _____

I authorize any holder of medical or other information about me to release any information needed to process this or other claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts the assignment.

Signature _____ Date _____

Do you have insurance? YES NO If yes, what kind? _____

Assignment of Insurance Benefits:

YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. We cannot guarantee payment of your claims or accept responsibility for negotiating claims with your insurance company. As a courtesy we will be happy to help you determine the coverage you have available. I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance and any other hearing health plans to Chicago Hearing Services. A photocopy of my insurance card and driver's license are to be considered as valid as an original. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or related services to pay the claim. I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Chicago Hearing Services to release all information necessary to secure the payment. If the insurance pays only a portion of the bill or fails to make payment within 90 days, I will be responsible for payment of balance in full at that time. I understand that, as I am responsible, any collection, legal fees or court costs incurred in attempt to collect this debt will be my responsibility.

Signature: _____ Date _____

Privacy Consent:

I have had the full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to use and disclosure of my protected health information and carry out treatment, payment activities and health care operations.

Signature _____ Date _____