Clarke Schools for Hearing and Speech: CLARKE HEARING CENTER

PATIENT INFORMATION/ CONSENT FORM/ ASSIGNMENT OF BENEFIT/RELEASE OF INFORMATION

PATIENT INFORMATION Last updated on: 7/28/2015

Name (last, first, MI):	**DOB**:	**Gender:**
Sallutation (Mr., Mrs., Ms., Dr.)	**Language**:	
Address:		
Marital status: single/married/widowed/divorced/partner:	**Spouse/Partner's name**:	
Patient's Home Phone#: **Work Phone#:**	**Cell Phone#:**	
Patient's Email address:	**Primary Care Physician:**	
Referral source:		
Alternate Contact: **Relationship:** **Alternate Contact Phone:**		
IF PATIENT IS A MINOR		
Parent A Name:	Parent A best phone:	Parent A email
Parent A: Address		
Parent B Name:	Parent B: best phone	Parent B email
Parent B Address		

INSURANCE INFORMATION: Primary Policy

Who is the policy through? **Subscriber Name**:	**Relationship**: **Subscriber's DOB:**
Employer:	Employer City & State:
Primary Insurance:	**Policy #**

INSURANCE INFORMATION

Subscriber Name:	**Relationship:**
Employer:	**Employer City & State:**
Secondary Insurance:	**Number:**

The above information is true to the best of my knowledge. I hereby authorize treatment.

_____ _____

SIGNATURE (patient or parent if minor) DATE

I will be responsible for any copay, coinsurance or deductibles as defined by my insurance policy. I understand it is my responsibility to obtain a referral or prior authorization if necessary for any procedures now or in the future. If a referral or prior authorization was needed for insurance reimbursement and was not obtained, I understand I am responsible for the full payment for the services rendered to me. _____ (initials) dated:_____

ASSIGNMENT OF BENEFITS: I irrevocably assign to you, my medical provider, all my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the health care carrier. I direct that all reimbursable medical payments go directly to you, my medical provider. SIGNATURE_____ DATE:_____

RELEASE OF INFORMATION: I understand that HIPAA allows Clarke to obtain medical information regarding my physical condition and *treatment from any other health care provider, including hospitals, diagnostic centers. etc.* and **I specifically authorize such provider(s) to release all such information to you about me**, including medical reports, radiological reports, narrative reports, and any other report or information related to the care I receive in your office. _____ (initials) dated: _____

USE AND DISCLOSURE: By signing below, I understand that the Clarke Hearing Center has a right to use and disclose my Protected Health Information under specific circumstances as outlined in the HIPAA Notice of Privacy Practices. I understand that I have the right to restrict how my Protected Health Information is used by Clarke if I pay privately or provide written opt out notice for fundraising and/or certain marketing activities (i.e. sale of PHI; where Clarke receives remuneration from third party for marketing activity). _____ (initials) dated: _____

I have read and initialed the above statements. I have been offered any opt out forms that I have requested. I have been offered a Clarke HIPAA Notice of Privacy Practices and encouraged to read same.

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SIGNATURE_____ DATE:_____