## ROCKY MOUNTAIN HEARING & BALANCE

### PATIENT REGISTRATION

**PATIENT NAME:** _____ Sex _____ Age_____

Home Phone _____ Cell Phone_____ Employer_____

Email Address _____ (for Rocky Mountain H&B use only)

Date of Birth _____/_____/_____ Marital Status_____ Soc. Sec. #_____-_____-_____

Home Address _____ City _____ Zip_____

How You Heard About Us _____

Referring Physician _____ Phone _____

Family Physician _____ Phone _____

**RESPONSIBLE PARTY:** _____ Relation to Patient _____

Address (street/city/state/zip)_____ Home Phone _____

Date of Birth _____/_____/_____ Employer_____ Work phone_____

**SPOUSE OR NEAREST RELATIVE:** Name _____Phone _____

**PRIMARY INSURANCE:** _____ Name of Policy Holder_____

SSN: _____-_____-_____ Date of Birth _____/_____/_____ Policy #_____ Group #_____

**SECONDARY INSURANCE:** _____ Name of Policy Holder _____

SSN: _____-_____-_____ Date of Birth _____/_____/_____ Policy # _____ Group #_____

I certify this information is true and correct to the best of my knowledge and hereby consent to treatment by the audiologists of Rocky Mountain Hearing & Balance, LLC. I hereby authorize the release of all pertinent information including diagnosis, examination records and treatment records to authorized persons. These records will be held in strict confidence and are not available to unauthorized persons. I have read the terms and conditions of the Notice of Privacy Practices, and hereby agree to abide to all terms and conditions as outlined. Rocky Mountain Hearing and Balance may use my home address and/or e-mail address to communicate current and future technology updates/offers related to my treatment.

I understand that cerumen (wax) removal from ear canal is not eligible for reimbursement by insurance. There is a charge of $25 per canal if this service is necessary. In the event that this procedure requires longer than 15 minutes, I will be charged at the rate of $40 per canal.

I understand that the Epley maneuver for dizziness (BPPV) is not paid for by Medicare and most other insurance companies. You will be notified before procedure is performed. If rendered, there is a charge of $75.00, payable at the time of services.

Rocky Mountain Hearing & Balance will bill the insurance company as a convenience to our patients. Any unpaid balance will be the patient's responsibility. If the insurance has not paid within 45 days there will be an interest charge of 1.5%.

The signee specifically agrees to pay all reasonable attorneys' fees and court costs in the event legal action is taken to collect on an account. The signee further agrees to pay an additional amount representing up to 50% of the principal balance if the account is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with said collection action processing.

Signed _____ Date _____