Integrity Hearing Services
7525 Custer Road W.
Lakewood, WA 98499

Patient Information

Full Name: _____/_____/_____
(Last Name) (First Name) (Middle Initial)

Preferred Name: _____ Date of Birth: _____/_____/_____ Social Security Number: _____

Address: _____/_____/_____/_____
(Street) (city) (State) (Zip Code)

Telephone (_____) _____ (_____) _____
(Home) (Cell Phone or Other)

E-mail address: _____ Preferred Method of Contact: Phone__ Email___ TTY__

Gender: Female___ Male ___ Marital Status: Single __ Married __ Divorced __Widowed __

HOW DID YOU HEAR ABOUT US? _____

Employer (check one): _____ Full time_____ Part time_____ Student_____ Retired_____

Occupation: _____

Emergency Contact: _____/_____/ (_____) _____
(Name) (Relationship to patient) (Primary Number)

Is patient a minor? No ___Yes ___ *(If yes please fill out ***Responsible Party*** below)

Is someone other than patient responsible for this bill? No ____Yes ____ *(Does ***NOT*** include ins. companies. If yes fill out ***Responsible Party*** below)

Responsible Party:

Full Name: _____/_____/_____
(Last Name) (First Name) (Middle Initial)

Date of Birth: _____/_____/_____Telephone (_____) _____Relationship to Patient_____

Primary Care Physician:

Physician Name: _____ Office Name: _____Phone: (_____) _____

Insurance:

Primary Insurance: _____ Secondary Insurance: _____

ID Number: _____ ID Number: _____

Group #: _____ Group #: _____

Policy Holder Name: _____ Policy Holder Name: _____

Policy Holder DOB: _____/_____/_____ Policy Holder DOB: _____/_____/_____

Insured Full Name: _____ Insured Full Name: _____

Insured Date of Birth: _____/_____/_____ Insured Date of Birth: _____/_____/_____

**********I authorize Integrity hearing Services, PS to release information requested with regard to processing my claims. I authorize and assign payment of benefits from my insurance company to Integrity Hearing Services, PS. under the terms of my insurance policy. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Integrity Hearing Services, PS of any changes in my health status or in the above information.

Signature: _____ Date: _____

If a Minor: Parent: _____ Date: _____

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Patient History Form

Patient Name_____ DOB_____ DOS _____ PCP_____

Why are you coming to see us?

_____

_____

When was your last hearing test? _____

When did you first notice hearing loss?

_____

Has your hearing worsened suddenly or gradually? _____

Which ear is your hearing worse (Circle One)?: Right Ear Left Ear Both are Equal

Are there any other factors you believe to have caused your hearing loss?

_____

Please check all that apply:

__ Ringing or other noises in your ears? __ History of Ear infections? __Pacemaker?

__ Ear Surgery? __ Measles/Mumps/Rubella? __Blood Thinners?

__ Earache or Ear Pain? __ History of loud noise exposure? __Diabetic?

__ Ear Drainage? __ Dizziness? __ Family History of Hearing Loss?

__ Ear Fullness/Pressure? __ Chemotherapy?

Please circle frequency of difficulty of hearing in each situation:

One on one conversations:	Never	Sometimes	Frequently	Always
Television:	Never	Sometimes	Frequently	Always
Small Groups/Family Gatherings:	Never	Sometimes	Frequently	Always
Quiet Restaurants:	Never	Sometimes	Frequently	Always
Noisy Restaurants/Parties:	Never	Sometimes	Frequently	Always
Telephone:	Never	Sometimes	Frequently	Always

Hearing Aid History:

Are you currently wearing hearing aids? ___Yes ___No

Have you ever tried hearing aids before? ___Yes ___ No

If yes, what benefits/problems have you had with them?

_____

_____

What type of hearing aids have you worn/are wearing? _____

Patient Name:_____

DOB:_____

DOS:_____

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Current Medication List

Medicare and some insurance companies require obtaining a current list of all your medications. Please list your medications to the best of your ability below or **mark the box below if you do not take medication**. If you have any questions please feel free to let us know. Thank you.

Are you smoker? Yes__ No__ **I do not take any medication.** ☐

Medication	Dosage	Route (Oral or IV)	Frequency	Ototoxicity *(Office Use Only)*

Medication Updates ***(For Office Use Only)***

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Financial Policy

Insurance and Assignment of Benefits:
Your insurance policy is between you and your insurance company. It is your responsibility to understand co pays, coverage, and eligibility. You authorize and assign payment of benefits from your insurance company to Integrity Hearing Services, PS. under the terms of your insurance policy. All charges are your responsibility regardless of if your insurance covers our services or not. If your insurance company requires a referral in order for you to be seen, it is your responsibility to obtain one for your file when you come in. As a courtesy to you, we will bill your insurance company if accepted here, for the services we provide. However, if the service is not covered by your insurance, information is incorrect, or any other denial reason, you will be responsible for the remaining balances.

No Insurance:
Your payment will be due at the time of service.

Co-Pays:
The co pays will be billed to your mailing address after the insurance company has made a payment, and sent us an explanation of benefits. You are responsible for the co pay your insurance company is having you pay.

L&I Claims:
If you have an L&I claim you will need to notify the front desk on your appointment date. We will need your L&I claim information including claim number for billing, and your claim managers contact information. If you do not give us this information, you will be responsible for the bill.

NSF Checks:
If a check is returned as NSF, there will be a $35.00 charge applied to your account, plus the amount of the check.

Care Credit/MasterCard/Visa:
Care Credit is its own entity; we are in no way affiliated with Care Credit, Visa, MasterCard or any other financial companies. We accept Visa, MasterCard and Care Credit.

Services:
Payment is due when services are rendered.

Hearing Aid Deposits:
Hearing aid payments are due at the time of order. If your insurance covers hearing aids, the portion you are responsible for will be due at the time of order unless prior arrangements have been made.

Delinquent Accounts:
If your account is overdue, you will receive a letter to your mailing notifying you that you need to make a payment. Delinquent accounts will be turned over to Quick Collect. It is understood and agreed that in the event any outstanding balance has to be referred to a collection agency for the recovery of the fees, you are fully responsible for any and all costs involved, including, but not limited to, attorney fees and collection agency service charges.

Refund Policy:
All accessories and refund items will be returned at full price before they are opened. Earmolds and earplugs are non-refundable. All hearing aid refunds will be returned within the trial period with the exception of a $150 fitting fee per ear which covers costs we cannot recover (i.e. shipping and handling, restocking and credit card fees). All payments made by Visa or MasterCard will be refunded back to the original card that the payment was made with. All other payments will be refunded by check.

I have read the above and understand the financial policies of Integrity Hearing Services, PS. I understand that I am responsible for my bill. By signing below, I am agreeing to these terms.

_____ _____

Signature of Patient or Responsible Party Date