ALUTIIQ HEARING SERVICES

Alutiiq Hearing Services
Cindy Weber, Audiologist

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There will be a $75 fee for cancellations with less than a 24 hour notification. $25 monthly fee for invoices not paid in full.

Welcome, we want to provide excellent hearing care to you. Please tell us a little about yourself by completing as much as possible on this form.

How did you hear about us? _____

PERSONAL INFORMATION:

Patient's Name _____
FIRST MIDDLE LAST

Mailing Address _____
CITY STATE ZIP

Telephone (Home) _____ (Work) _____

Birth Date _____ Age _____ Male _____ Female _____ Marital Status _____

Alaska Native ____Yes____No Tribal Member of _____

Military Service_____Yes_____No _____Active _____ Retired _____Branch

Full Name and Phone Number of Primary Physician _____

Name and Telephone of nearest relative_____

Email Address _____May we contact you via email? Yes ____ No ____

INSURANCE INFORMATION - PLEASE READ AND SIGN/INITIAL:

Disclaimer: **Alutiiq Hearing Services** will bill your **primary insurance only**, no secondary insurance will be billed. ***Patient*** *is responsible for* ***paying a fee of $150.00*** *at time of visit* ***with the remainder being billed to insurance.*** By signing below, I have read and understand the financial responsibility and understand that **regardless** of my **insurance status**, I am ultimately **responsible** for the **balance of my account** for any services rendered. **I understand that I am responsible for payment.**

PLEASE INITIAL: _____

Medicare_____ No_____ Yes# _____ Medicaid_____No _____Yes # _____

PLEASE BRING YOUR INSURANCE CARD(S) WITH YOU TO BE COPIED FOR YOUR FILE.

If the health insurance is not in your name, please provide the following information:

_____ Name of Insured

_____ Relationship to Patient

_____ Address of Insured

_____ Insured's ID and Group #

_____ Insured's Date of Birth and SS#

_____ Insured's Employer

I hereby authorize Cynthia Weber, Audiologist and her associate(s) to furnish information to my insurance carrier concerning my illness and treatment and I hereby assign to her all payments for services rendered to my dependents or myself. I understand that I am responsible for payment.

Signature _____ Date _____

PLEASE READ AND SIGN/INITIAL:

***Privacy Practice Notice*: According to government law, we are required to make available to you a copy of our privacy practice notice. Your signature below acknowledges your receipt of such:**

Signature: _____ Date: _____