Daniel Island Hearing Center
899 Island Park Drive
Suite 200A
Daniel Island, SC 29492
843-971-4199

Patient Information

Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Gender: Male Female**

Primary Phone (Home, Work, Mobile): _____ **Email:** _____

Secondary Phone (Home, Work, Mobile): _____

Employment Status: Full-Time Part-Time Retired Not Employed Other

Employer (if applicable): _____

Please circle if you are a student:
Full-Time or Part-Time

Marital Status: Single Married Divorced Widowed Other

Primary Care Physician: _____

How did you hear about us? _____

If you have a Patient Representative, please fill out the relevant fields below.

Representative's Name: _____ **Relationship to Patient:** _____

Address: _____ **City, State, and Zip:** _____

Primary Phone (Home, Work, Mobile): _____

I authorize communication with my representative regarding appointments, insurance and claims issues and hearing aid purchase, repair and warranty issues.

Signed: _____ **Date:** _____

I give my consent for Daniel Island Hearing Center to mail general correspondence such as: appointment notices, reminder notices, warranty notices, newsletters and special event notices to my mailing address. I understand that my information and address **will not be sold or shared** and will only be used by Daniel Island Hearing Center for personal communication or insurance claims purposes.

Signed: _____ **Date:** _____

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 assignment.

Signed: _____ **Date:** _____

Jennifer Esse, Au.D
Doctor of Audiology
dihc@bellsouth.net
www.danielislandhearing.com

Daniel Island
HEARING CENTER
Hear Well, Live Well

843.971.4199
843.971.4292 fax
899 Island Park Drive 200A
Daniel Island, SC 29492

Notice of Privacy Practices
This notice describes how medical information about you may be used and disclosed, and also how you can get access to this information. Please review it carefully.

All patients have the right to know that their personal health information remains confidential. The privacy rights and practices of Daniel Island Hearing Center were established to protect the healthcare information of our patients, as required by Section 164.520 of the Health Insurance Portability and Accountability Act of 1966. These guidelines restrict the release of your medical information for the purpose of treatment, payment, and healthcare operations. **Although many will not apply to you, the following are examples of agencies or facilities to which your personal health information may be released in the course of your treatment:**

- Health Insurance Providers
- Pharmacies
- Laboratory Testing Facilities
- Hospitals
- Physician Consults
- Surgical Facilities
- Physical Therapies
- Physician Intern Training

Other uses or disclosures permitted or required by law:

- Public Health Activities
- Health Inspection agencies
- Law Enforcement Purposes
- Workers' Compensation
- Judicial Proceedings
- Reporting Abuse, Neglect, or Domestic Violence
- Disclosures about Descendants (Coroner/Funeral Director)
- Avert Serious Threat to Public Health or Safety
- Specialized Government Functions (Military or Veterans' Activities)

The release of healthcare information to any other source is prohibited without the written authorization of the patient or guardian. As a patient or guardian you have the right to:

- Request Restrictions on Certain Uses and Disclosures of Your Healthcare Information
- Inspect and Request Changes to Your Medical Records
- Obtain a Copy of Your Medical Record (Fee Charged for Copies)
- Be Informed of Any Disclosures of Your Records that Have Been Made
- Receive Confidential Communications
- Ask Questions about the Privacy Policy
- File a Complaint with Daniel Island Hearing Center or to The Secretary of Health and Human Services Without Fear of Any Reprisals, if You Believe that Your Privacy Rights Have Been Violated.

Acknowledgement of Receipt of Notice of Privacy
□ By checking this box and signing below, I acknowledge that I received a copy of Daniel Island Hearing Center's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

Patient's Name (please print): _____

Patient's Authorized Signature: _____ **Date:** _____

Jennifer Esse, Au.D
Doctor of Audiology
dihc@bellsouth.net
www.danielislandhearing.com

Daniel Island
HEARING CENTER
Hear Well, Live Well

843.971.4199
843.971.4292 fax
899 Island Park Drive 200A
Daniel Island, SC 29492

Financial Policy
As a courtesy, we will be happy to file the claim for your hearing evaluation if we participate with your insurance company and if the insurance company will accept electronic claims. We will file claims to Medicare when Medicare is your primary insurance. We are unable to file secondary claims to Medicare.
We are unable to file claims to Medicare Railroad. We do not automatically file claims for hearing aids, as coverage is not typical and requirements vary greatly. If you feel you may have some hearing aid benefits, please advise us so we can help you to clarify what benefits you may have and how to best proceed. **You are responsible for any charges not covered by your insurance.** Medicare will cover an initial, one-time hearing evaluation, when hearing loss is the primary symptom or diagnosis. An annual deductible and a co-payment of 20% apply. If you have a supplemental policy, it may cover your co-pay or deductible. **Repeat and annual hearing evaluations are typically not covered by Medicare. The fee for a non-covered repeat or annual hearing evaluation is currently $65.00. You will be asked to sign an additional form, required by Medicare, in this circumstance.**

Use and Disclosure
I hereby authorize Daniel Island Hearing Center to use my healthcare information and to disclose such information to my insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for the related services.

Assignment of Benefits
I hereby authorize payment of insurance benefits to be made directly to Daniel Island Hearing Center for services rendered. Additionally, I authorize Daniel Island Hearing Center to release any information necessary to secure payment of insurance benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Privacy Practices
I hereby acknowledge that I have read and understand the Notice of Privacy Practices for Daniel Island Hearing Center, LLC & do not wish to receive a copy. (Please ask Practice Manager if you would like a copy for your records.)

Lifetime Medicare B and/or Independent Insurance Signature Authorization
I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare or Independent insurance claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services OR authorize such physician or organization to submit a claim to Medicare or independent insurance company for payment to me.

By signing below, I agree to the following:
I understand that I am responsible for all charges that are not paid by insurance. I understand that balances are due upon receipt of statements and Finance Charges may be applied to account balances that are not paid within 30 days of initial statement date. Furthermore, I hereby authorize:

- the use of this form on all my insurance submissions
- release of information to all my Insurance Companies
- Daniel Island Hearing Center, LLC to act as my agent in helping me obtain payment from my Insurance Companies
- direct payment to Daniel Island Hearing Center, LLC
- that a copy of this form be used in place of the original
- that I will be on the Daniel Island Hearing Center mailing list but that my information is not sold or shared with any other firms, companies or entities

Signature: _____ **Date:** _____