Windsor Audiology
Hearing and Tinnitus Clinic

Northern Colorado's premier hearing care professionals
Your hearing healthcare journey begins here

First Name: _____ **Last Name**: _____ **Today's Date**: _____

Phone Number: _____ **Date of Birth**: ___/___/_____ **Email**: _____

Street Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Current Insurance: _____ **Member Number**: _____

Secondary Insurance: _____ **Member Number**: _____

Please circle your below answers:

Do you have any of the following: **Ear Pain** **Fullness in Ears** **Vertigo** **Ringing** **Buzzing** **None**

Do you use tobacco products: **Yes** **No**

Do you have Tinnitus: **Yes** **No**
If yes, on average, how has your tinnitus been over the past month?:
(Hardly noticeable) 1 2 3 4 5 6 7 8 9 10 (Painfully loud)

Do you wear hearing aids?: **Yes** **No**
If not, would you like to discuss hearing aids?: **Yes** **No**

History of exposure to loud noises?: Machinery Firearms Construction Other: _____

Family history of hearing loss?: Mother Father Siblings Maternal Grandparents Paternal Grandparents

Primary Care Physician: _____
Do you want your report sent to your primary care provider: **Yes** **No**

Current Medications/Supplements - you can email a copy of your medications to info@windsoraudiology.com

_____ _____ _____

_____ _____ _____

Please list any other information you feel is important regarding your hearing healthcare or health changes:

_____

_____

CERUMEN REMOVAL DISCLAIMER

I understand that in order to accurately receive a diagnostic evaluation of my hearing, my ears must be clear of any obstructions, including blockages caused by wax. If there is wax present in my ears at the time of my visit, I understand that Windsor Audiology cannot bill my insurance for wax removal, and there will be an additional out-of-pocket cost associated with removing the wax prior to completion of my hearing evaluation. Furthermore, I understand that my hearing care provider will disclose costs and more detailed information on the cerumen removal procedure if it is found to be necessary during my visit.

_____ _____

Print Patient's Name Signature

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT - HIPAA

By signing below, I acknowledge that I have read and understood this information. **I also acknowledge that I have access to the HIPAA privacy policy at my request (a copy is provided on the website at windsoraudiology.com and in the office)** and fully accept the agreements laid forth in the HIPAA for Windsor Audiology.

_____ _____

Print Patient's Name Signature

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Patient Name: _____ DOB: _____Date of Notice: _____

NOTE: If your insurance carrier does not pay for the services below, you may have to pay.
Your insurance plan (Medicare or commercial private plan) does not pay for everything, even some care that you or your healthcare provider have good reason to think you need. We expect your insurance carrier may not pay for the services listed below.

Service or items	Reason:	Estimated Cost
Comprehensive Evaluation	Typically Covered and/or applied to deductible	$65.00
Pure Tone – Air Conduction	Typically Covered and/or applied to deductible	$50.00
Speech Discrimination	Typically Covered and/or applied to deductible	$50.00
Billed to Insurance	**May apply to deductible**	**$65.00 or $100.00**
Hearing Aid/TRT Programming	**Non-Covered Service**	$75.00
Cognivue Assessment	**Non-Covered Service**	$25.00
Due at Time of Service	**Total Cost of Non-Covered Services**	**$25.00 - $75.00**

WHAT YOU NEED TO DO NOW:

- Read this notice so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the services listed above.

Note: If you choose Option 1 or 2, we may help you use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the services listed above. You may ask to be paid now, but I also want my insurance carrier (Medicare or private commercial insurance) billed for an official decision on the payment, which is sent to me on a Medicare Summary Notice (MSN) or Explanation of Benefit (EOB). I understand that if Medicare or other private commercial insurance does not pay, I am responsible for payment, but I can appeal to Medicare or other commercial insurance following the directions on the MSN or EOB. If Medicare or other commercial insurance does pay, you will refund any payments I made to you, less copays or deductibles.

☐ **OPTION 2.** I want the services listed above, but do not bill Medicare or private commercial insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare or private commercial insurance is not billed.**

☐ **OPTION 3.** I do not want the services listed above. I understand with this choice, I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

This notice gives our opinion, not an official decision. If you have other questions on this notice, contact your insurance carrier.

SIGNATURE	DATE

CMS will work with its contractors to ensure consistency when determining validity of the ABN in general. In addition, contractors will provide ongoing education to notifiers as needed to ensure proper notice delivery. Notifiers should contact the appropriate CMS regional office if they believe that a contractor inappropriately invalidated an ABN.