Windsor Audiology
Hearing and Tinnitus Clinic

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

Patient Intake

Today's Date: _____

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

Address: _____ **City/State/Zip**: _____

Phone Number: _____ **Email:** _____

Insurance Information – please provide us with a copy of your insurance card at time of visit

Primary Insurance Company: _____

Provider Service or Customer Service Phone Number on back of card: _____

Name of Insured: _____ DOB of Insured: _____

Policy #: _____ Group #: _____

Primary/Referring Physician's –
****MUST BE COMPLETED TO ENSURE PROPER INSURANCE BILLING/PAYMENT****

Physician's Name: _____ Please send report to my physician: ____ **Yes** ____ **No**

Office: _____ City/State: _____

HEALTH INSURANCE AND 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

How did you hear about us? We would love to know who to thank for sharing our name!

❑ Friend or Current Patient, if so Name _____
❑ My Doctor ❑ Google ❑ Other Search Engine ❑ Newspaper or Magazine
❑ Other _____

Medical and Hearing History

Date and place of last hearing test if known: _____

Results of last hearing test: _____

Do you currently have symptoms:	Yes	No	Comments:
History of Hearing Loss			If yes, date of onset:
Family History of Hearing Loss			Circle the family members with history loss: Mother Father Siblings Maternal Grandparents Paternal Grandparents
Ear Disease or Surgery			If yes, list type and date:
Ears Feel Full or Pressure			
Ear Pain			
Dizziness or Vertigo			
Tinnitus or Ringing			
Teeth Grinding or Clenching			If yes, do you wear a bite guard?
History of Exposure to Loud Noises			If yes, please circle the source: Loud Machinery Firearms Construction Other:
Do You Smoke			
Have You Had Cancer			If yes. please list type and date:
Do You Have Allergies			If yes, list what types:
Do you have a Inflammatory or Rheumatic Disease like Arthritis, Lupus or Fibromyalgia			
Head Trauma (MVA or concussion)			

Circle if you have or have ever had any of the following:

Anemia	Asthma	Alcoholism or Substance Abuse	Diabetes
Hypertension (Blood Pressure)	Kidney Disease	Hepatitis or Jaundice	Gout
Memory Problems	Thyroid Problems	Chronic Lung Disease	Stroke
Osteoporosis	Migraine Headaches	Depression, Anxiety or PTSD	HIV/AIDS
Epilepsy	Syncope (Fainting)	Autoimmune Disease	Menieres

Other: _____

Current Prescription List

Please provide below or email your current medication list to info@windsoraudiology.com:

Medication	Dosage	How often?

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 cerumen removal procedure if it is found to be necessary during my visit.

_____ _____

Print Patient's Name Signature

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

Protected Health Information Release

Individual Persons:
I give Windsor Audiology permission to release my healthcare information to the following individuals.
This line may be left blank if you chose. **Please note that we will not be able to release any information regarding you, your hearing aids, your test results or your appointments to anyone not on this list.**

Individuals can include spouses, family members or friends.

1) _____ 2) _____

3) _____ 4) _____

Physician Office:
I give Windsor Audiology permission to release information regarding my hearing health to my physician's office.

Office or Physician Name: _____

Detailed Voicemail

- ☐ Windsor Audiology has permission to leave a detailed voicemail regarding my hearing healthcare including but not limited to; appointments, repairs, test results, and costs.
- ☐ Windsor Audiology DOES NOT have permission to leave a detailed voicemail message regarding my hearing healthcare.

Electronic Communications i.e.: Email or Text

- ☐ I allow Windsor Audiology to communicate my personal healthcare information to me through unsecured forms of electronic communication, such as responding to questions and appointment confirmations.
- ☐ I DO NOT allow Windsor Audiology to send my personal healthcare information to me through electronic communications.

Marketing and Newsletters

- ☐ I would like to receive Quarterly Hearing Healthcare E-Newsletters and other special offers to my email.
- ☐ I DO NOT want to receive Quarterly Hearing Healthcare E-Newsletters or other special offers to my email.

I understand that this form will remain valid until I have provided a written request for Windsor Audiology to change, or cancel any and/or all parts of the release.

Patient Signature: _____ Date Signed: _____

Missed Appointment Policy

Our goal is to provide quality audiologic care in a timely manner

Please be respectful of the needs of other patients by calling Windsor Audiology 24-hours prior to your appointment time if you are unable to attend. This policy applies to all patients, new and established. This time will be reallocated to someone who is in need of treatment. Appointments are in high demand, and your early cancellation will give another patient the possibility to have access to timely medical care.

A "no-show" is an individual who misses an appointment without canceling prior to the date and time of their scheduled appointment. This also refers to not arriving with enough time to complete the paperwork needed prior to the appointment.

If you reschedule more than three times, we will need an updated physician referral.

Failure to be present at the time of the aforementioned appointment will result in a missed appointment fee of $25.00. If this occurs more than twice, the fee will be increased to $50.00.

Printed Patient Name: _____

Patient Signature: _____

Date: _____

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Advance Beneficiary Notice of Non-Coverage Patient Financial Responsibility - Diagnostic Hearing Evaluation

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
Diagnostic Hearing Evaluation	Typically Covered and/or applied to deductible	$65.00 - $165.00
Tympanometry and Reflex	Typically Covered and/or applied to deductible	$25.00 - $50.00
Billed to Insurance	**May apply to deductible**	**$90.00 - $215.00**
Cognivue Thrive Screening	**Non-Covered Service**	$25.00
Hearing Aid or Tinnitus Consultation	**Non-Covered Service**	$100.00
Due at Time of Service	**Total Cost of Non-Covered Services**	**$125.00**

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 co-pays 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.

FINANCIAL POLICY

At Windsor Audiology, we feel transparency is part of patient care. Therefore, it is our policy to inform our patients upfront of the cost and benefits available to them. "We ask that you realize that we do NOT work for your insurance company. Rather, we work 100% for our patients. We feel that insurance can be a great benefit for many patients and want you to know we will do everything in our power to ensure you get every benefit allotted in your insurance contract. We will also be completely transparent with our pricing and what benefits you have. However, the treatment we recommend and the fees we charge will always be based on your individual needs, not your insurance coverage."

Please read and initial each of the following statements, letting us know that you understand them. If you have questions regarding these statements, please let the staff know so we can help you understand them better.

_____ 1. You are responsible for all fees associated with the care you receive in our office. Payment for our services is due at the time of your visit unless other arrangements have been made in advance.

_____ 2. We will make every attempt to work with your insurance company to use all your allotted hearing benefits. We will perform a courtesy benefit when the insurance information is provided 48 hours or more prior to the appointment, and will gather as much reliable information regarding your benefits as possible. However, it is ultimately your responsibility to know and understand your benefits and coverage. You are responsible for ALL co-pays, co-insurance, deductibles, and non-covered fees that your insurance company deems patient responsibility. Should your claim be all or partially denied, we will submit one appeal on your behalf. If we do not receive payment from your insurance company within 90 of claim or appeal submission, you will be responsible for the remaining balance due.

_____ 3. As stated above, we will make every reasonable attempt to collect your benefit from your insurance company. Once a final patient responsibility has been established, we will send you an invoice for your portion of the service. We expect payment within 30 days of receipt of your first invoice. After each 30 days of non-payment we will add a rebilling fee of $20 and reissue your statement to the address and email on file. After 90 days of non-payment from the initial billing date we will proceed to send your bill to collections, you will be charged an additional rebilling fee of $20 dollars plus an additional 38% to the total bill submitted to collections. If further action is required you will also be responsible for all court costs, attorney fees, and collections charges.

_____ 4. Our office is not a Medicaid provider and if you have Medicaid as part of your insurance benefits please speak with our staff immediately.

_____ 5. I understand that Windsor Audiology offers credit options through Wells Fargo Financing and if I choose to use Wells Fargo that I follow the financial policy put forth by Wells Fargo or Care Credit, as well as Windsor Audiology.

I, _____ have fully read and understand Windsor Audiology's Financial Policy. I agree to the terms of this policy and that if I choose to opt out of this financial policy by not signing that Windsor Audiology has the right to refuse service to me.

Signature: _____ Date Signed: _____

Patient Signature or Legal Representative