EVERCLEAR HEARING PRODUCTS, LLC
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Eau Claire, WI 54701
715-831-0289

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PATIENT INFORMATION

Name: First, MI, Last ____________________
Date of Birth ____________ Age ________
Patient Gender ____________
Marital Status ____________
Address ____________________
City ____________________
Phone# ____________ Cell# ____________
State ____________ Zip Code ____________
Patient's Employer ____________________
Patient's Email Address ____________________
Refered By M.D.: ____________________
Primary Care M.D.: ____________________
Referral Clinic: ____________________
Primary Clinic: ____________________

RESPONSIBLE PARTY

Name ____________________
Date of Birth ____________________
Address ____________________
Relationship ____________________
City ____________ State ____________ Zip Code ____________
Phone: ☐ Home ☐ Work ☐ Cell
Phone: ☐Home ☐Work ☐Cell

PRIMARY INSURANCE HOLDER INFORMATION

Primary Insurance Company ____________________
Policy Holder Name ____________________
ID Number ____________ **Group Number** ____________
Date of Birth ____________ Relationship ____________
Employer Plan: ☐Yes ☐No
Employer ____________________

SECONDARY INSURANCE HOLDER INFORMATION

Secondary Insurance Company ____________________
Policy Holder Name ____________________
ID Number ____________ **Group Number** ____________
Date of Birth ____________ Relationship ____________
Employer Plan: ☐Yes ☐ No
Employer ____________________

Who may we thank for referring you to our clinic?

Physician Name____________ Friend ____________ Ins Comp________ Family _____Other ________

1. Insurance. Insurance is a contract between you and your insurance company. We will be happy to assist you in checking with your insurance carrier for clarification of coverage once we have a copy of your insurance card. We participate in most insurance plans, including Medicare/Medicaid. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

Signature ____ Date____________

4. Proof of insurance. (If applicable) All patients must complete our patient information form before seeing the provider. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim or not. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 60 days, the balance will automatically be billed to you. We will make every effort to assist in getting your claim paid.

Assignment of Benefits: I hereby assign all benefits to which I am entitled and authorize the release of any information relating to all claims submitted on behalf of myself and/or dependents. I hereby authorize and direct my current and future insurance carrier(s), including Medicare, private insurance, and any health/medical plan, to issue payment directly to: Everclear Hearing Products.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am responsible for all charges whether or not paid by said insurance.

________________________________ ____________________

Signature of patient or responsible party Date