Joseph J. Holmes Au.D.
Board Certified by the American Board of Audiology

Patient Information

Name
Dr. /Mr. / Mrs. / Ms. / Miss____
(Circle one) First Middle Last Companion Name

Address______________________________ City:______________ State:____ Zip:__________

Day Phone:________________ Other Phone:______________ Mobile Phone:________________

Gender: Employment Status:
O M **O** Employed **O** Student FT / PT Email:________________________

O F **O** Retired **O** Other Fax: ________________________

Marital Status: Date of Birth:__________ Social Security Number: ____________________
O Single
O Married Family Doctor:____________________ Phone:________________

O Other Referring Doctor:__________________ Phone:________________

Would you like results sent to your family doctor? **Y / N** (circle one)

How did you find out about us____

Guarantor Information (if patient is a minor)

Parent / Legal Guardian (Guarantor):________________________ Social Security Number:__________

Address:________________________ City:______________ State:___ Zip:______________

Day Phone:________________ Other Phone:______________ Mobile Phone:______________

Insurance Information: Please provide Insurance card(s) with this completed form

Policy Holders Name:________________ Policy Holders Date of Birth:________________________

Address:________________________ City:______________ State:___ Zip:______________

Day Phone:______________________ Social Security #:____________________________

Insurance Company:________________ Insured's ID:________________________________

Insured's Policy Group:______________ Policy Holders Relationship:

Insured's Plan / Program Name:____________ **O** Self **O** Child

Are you on Medicare: **Y / N** (circle one) **O** Spouse **O** Other

Policy Holder's Employers Name:____________________ Phone:________________________

Secondary Insurance Information:

Policy Holders Name:________________ Policy Holders Date of Birth:________________________

Address:________________________ City:______________ State:___ Zip:______________

Day Phone:______________________ Social Security #:____________________________

Insurance Company:________________ Insured's ID:________________________________

Insured's Policy Group:______________ Policy Holders Relationship:

Insured's Plan / Program Name:____________ **O** Self **O** Child

Are you on Medicare: **Y / N** (circle one) **O** Spouse **O** Other

Policy Holder's Employers Name:____________________ Phone:________________________

Holmes Audiology LLC

Worker's Compensation Information:

Worker's Comp Company Name:________________________ Adjustor's Name:______________________________________

Claim Number:______________________________________ Date of Injury:____

Employer's Name:____

Preferences:

Special Needs:____

Best time of day to contact you:____

Other:____

Financial Agreement:

We will file your insurance claims for the companies with whom we are contracted. You will be responsible for any co-payments . or deductibles at the time services are rendered. For some other insurance we accept assignment of benefits but in all cases we require that the guarantor, the person who is financially responsible, is personally liable for all balances not covered by insurance. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance companies. You will be responsible for co-payment, deductibles, out-of-network amounts or any portion your insurance company states you are responsible for. Payment for co-pays is expected at the time of service. If this fee is not covered by insurance it will be your responsibility. We allow your insurance company 45 days to pay your claim. If we do not receive payment in 45 days, you will be given a bill at that time. For our HMO/PPO patients, if we are contracted with your HMO/PPO, you will not receive a bill until we have heard from your insurance company.

Assignment of Insurance Benefits:

I hereby authorize direct payment to Holmes Audiology LLC of any insurance or health benefits otherwise payable to or on behalf of the patient for examination, treatment, or devices delivered to me by Holmes Audiology LLC, at the rate not to exceed Holmes Audiology LLC's usual charges. I understand that verification of insurance coverage obtained over the phone is estimated and does not guarantee payment and that insurance coverage is a relationship between the patient and his or her insurance company(s). I agree to accept financial responsibility for any charges for goods and services rendered to the patient that are not paid by insurance or health benefit plan pursuant to this assignment of benefits. I have been informed that Medicare does not provide payment for hearing aids, other assistive listening devices or fitting examinations.

Release of Information:

I authorize Holmes Audiology LLC to disclose and furnish copies of any information relating to my care at Holmes Audiology LLC (including any information related to substance abuse, mental health, HIV/AIDS, or other sensitive issues), to: any person or health care provider Holmes Audiology LLC believes to be involved in my care; any third party payor or other party thay may provide health-related benefits to me or may be financially responsible for the services I receive; any other person or organization I may specify in writing; and as allowed by applicable state and federal law, any other persons or organizations as necessary for my treatment payment,or Holmes Audiology LLC's health care operations. In certain cases, such as when I request to have my records sent to another provider, I understand that Holmes Audiology LLC may charge me, and I agree to pay, a copying fee for Holmes Audiology LLC's costs in photocopyingor otherwise reproducing the records. I understand that I may revoke this consent at any time by giving written notification to Holmes Audiology LLC. This cosent expires on the earlier of (a) the date Holmes Audiology LLC receives a written notice of revocation; or (b) the date that the consent expires in accordance with the governing law. I understand that my revocation will be ineffective to the extent Holmes Audiology LLC has relied upon the permission granted in this consent. I understand that a more detailed description of my rights regarding my records can be found in Holmes Audiology LLC's Notice of Privacy Practice

Holmes Audiology LLC

Financial Responsibility Agreement by Other than Patient's Legal Representative:

I agree to accept financial responsibility for the goods and services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Benefits, and Release of Information provisions above.

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I am acknowledging that I have received a copy of Holmes Audiology LLC's Notice of Privacy Practices.

Informed Consent

Holmes Audiology routinely performs otoscopy, audiometry, tympanometry, immitance testing, hearing aid evaluations, tinnitus evaluations, and probe-tube microphone measurements in-situ. By signing below, you give your consent for Holmes Audiology to carry out such proceedures as may be necessary to identify the nature of your complaint and offer specific recommendations.

Signatures:

I have read and agree to the terms above and on page one and page two of this form.

____ ______________________________

Signature of Patient or Legal Representative | Date

____

Printed Name of Signator

____ ______________________________

Signature of Insurance Policy Holder | Date

____

Printed Name of Policy Holder

____ ______________________________

Relationship to Patient | Witness (Holmes Audiology LLC)

Holmes Audiology LLC, 3926 Dayton Blvd, Red Bank, TN 37415
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