Patient Demographic Form

Patient Information

(Circle One) **Mr./Mrs./Ms./Miss/Dr.:** _____
First Middle Last

Gender: ☐ Male ☐ Female **Date of Birth:** _____ **Social Security #:** _____
(optional, REQUIRED for TriWest and DOR recipients)

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

Secondary Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Phone: _____ Cell / Home / Work **Secondary Phone:** _____ Cell / Home / Work

Email Address: _____ **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Primary Doctor: _____ **Office Phone:** _____

Referring Doctor: _____ **Office Phone:** _____

How did you hear about Sonus?

☐ Insurance/Physician Referral ☐ Internet ☐ Signage ☐ Mailer/Newspaper ☐ Friend/Colleague ☐ Other

Insurance Information

A copy of your card(s) is Required. Please supply ALL cards to a Sonus Representative.

Primary Insurance: _____ **Secondary Insurance:** _____

Work Comp Company: _____ **Claim #:** _____ **Date of Injury:** _____

Adjuster's Name: _____ **Phone #:** _____

Policy Holder Information (if Patient is not the Primary Subscriber)

(Circle One) **Mr./Mrs./Ms./Miss/Dr.:** _____
First Middle Last

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

Primary Phone: _____ Cell / Home / Work **Secondary Phone:** _____ Cell / Home / Work

Gender: ☐ Male ☐ Female **Date of Birth:** _____ **Social Security #:** _____
(optional, REQUIRED for TriWest members)

Employer's Name: _____ **Office Phone:** _____

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Release of Information

I hereby authorize Sonus to release any medical information about the patient necessary to determine liability for payment and to process any claim for examination, treatment or devices received by the patient. I also authorize Sonus to release the medical records of the patient to the patient's referring physician or family physician indicated on the first page of this form.

Financial Agreement

Payment for services rendered is due at the time of service. Upon request, Sonus will file your insurance claims for all services rendered. The patient or guardian, if patient is a minor, is ultimately responsible for the payment for devices, treatment, and care. Sonus will bill your insurance based on the most updated and correct insurance information supplied by the patient or responsible party. Patients or guardians are responsible for payment of all co-payments, co-insurances, and deductible amounts associated with the benefits billed to their insurance plan, including services deemed "non-covered services". Co-payments, co-insurances, deductibles, and cost of non-covered services, are due at the time services are rendered. If payment is not collected at the time services are rendered, payment is due within 30 days from receipt of bill.

Patient may incur additional charges where applicable, and is responsible for payment of these charges. Charges may include:

-Returned Check Fee: $25.00

-Missed Appointment/Late Cancellation Fee: $25.00

-Office Visit Fee: $30.00 (per visit, after warranty expiration)

Please initial each line and sign and date the bottom of this form, acknowledging you have read and understand each statement and this form in its entirety.

_____ I understand that any benefits quoted are an **estimate**, based on plan details supplied by my insurance carrier to Sonus.

_____ I understand that I am financially responsible for any balance not paid by my insurance carrier.

_____ I authorize Sonus Hearing Care Professionals and associated entities to bill my insurance carrier for services Sonus is rendering or has rendered.

Assignment of Insurance Benefits

I authorize direct payment to Sonus of any insurance or health benefits otherwise payable to the patient for treatment or devices. I understand any figures presented to me are estimates and they are not a guarantee of payment. Insurance coverage and payment is based on the contract between the insurance carrier and the patient, and Sonus and the patient's insurance carrier. I am financially responsible for any balance related to good or services rendered by Sonus that have been billed to my insurance carrier on my behalf. I agree to accept financial responsibility for any charges not paid by my insurance. I am aware that Medicare does not pay for hearing devices or fitting examinations.

Financial Responsibility Agreement for those other than Client's Legal Representative

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

I have read and agree to the terms outlined above.

_____ _____

Signature of Patient or Legal Representative | Date

_____ _____ _____

Relationship to Patient | Sonus Witness Signature | Date