

Your Clinic Name
Address
City, State, Zip

Ph#: Fax#:

ACCOUNT INFORMATION (Person Responsible for Payment)

Name _____ Sex ____ (M) ____ (F) Birthdate _____
Address _____ (City) _____ (State) _____ (Zip) _____
Employer _____ Employer Address _____
Home Phone _____ Work _____ Mobile _____ Email _____
Soc Sec # _____

PATIENT INFORMATION

Patients Name _____
Marital Status: (M) Married (S) Single (W) Widowed (D) Divorced (O) Other Sex: _____ (M) _____ (F)
Soc Sec # _____ Birthdate _____
Address _____ (City) _____ (Zip) _____
Employer _____ Employer Address _____
Employment Status (F) Full Time (P) Part Time (R) Retired (N) Not Employed
Referring Practitioner _____
Home Phone _____ Work _____ Mobile _____
Email _____

CONTACT INFORMATION

Name _____ Relationship to patient _____
Address _____
Home Phone _____ Work Phone _____ Mobile _____
Email _____

PRIMARY INSURANCE

Insurance Co. _____
Policy Holder _____
Policy Holder Address _____
Policy Holder Employer _____
Policy Holder Sex _____ (M) _____ (F)
Policy Holder Date of Birth _____
Policy Holder Relation to Patient _____

SECONDARY INSURANCE

Insurance Co. _____
Policy Holder _____
Policy Holder Address _____
Policy Holder Employer _____
Policy Holder Sex _____ (M) _____ (F)
Policy Holder Date of Birth _____
Policy Holder Relation to Patient _____

RELEASE AND ASSIGNMENT: I, the undersigned certify that I (or my dependent), have insurance coverage with the above listed insurance company and assign directly to Yakima Valley Hearing and Speech Center. all insurance benefits. I understand that I am financially responsible for all charges that are not payable by insurance and any balance remaining after sixty days. Overdue accounts will be charged a late fee of 1% per month or a minimum of \$10.00 per month billing fee. There will be a \$30.00 return check fee. **I understand that it is my responsibility to check with my insurance to see what my benefits will be and if my plan pays in or out of network. I realize that you have verified this, however, that it is not a guarantee of benefits or payments.** I also authorize the release of my medical and billing information to my insurance company and physician if requested.

Patient Signature (if under 18, parent/guardian must sign)

Date

24-HOUR LATE CANCEL/NO SHOW POLICY: We have a 24-hour late cancellation/no show policy. If you fail to show up for your scheduled appointment you will be charged the \$45.00 fee. Please call us 24 hours in advance to cancel/reschedule your appointment. Failure to do so will result in a \$45.00 charge. This charge will be an out of pocket expense and can not be billed to your insurance company.

Patient Signature (if under 18, parent/guardian must sign)

Date