SOUNDS GOOD AUDIOLOGY SERVICES PLLC

Dr. Talley Dabakarov AuD CCC-A
86-25 Lefferts Boulevard
Richmond Hill, NY 11418
718-327-EARS (8477)

PATIENT INFORMATION __New Patient __Name Change __Address Change __ Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS:

Today's Date ____/____/____
Name ____ Preferred nickname ____________
Last, First M.I.
Date of Birth: ____/____/____ Age: ____ Social Security # _________________ Sex: __Male __Female

ADDRESS:
Mailing Address
____ House #
Street name City State Zip
Home Phone: (_______)______________________
Work Phone (_______)_____________________________________
Cell Phone: (_______)_______________________________________
email: ____

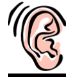
Marital Status: __Single __Married __Divorced __Widowed __Separated __Dom. partner__other

PARENT, SPOUSE, OR RESPONSIBLE PARTY (if different from patient)

Name: ____________________________________ Date of Birth _____________
Last First M.I.
Address: ____
Home Phone: (_______)____
Work Phone: (_______)_________________________________

INSURANCE COVERAGE - PRIMARY:
Insurance Co. Name:_______________________________________
Phone: (_______)________________________________
Address of Claim Center: ____
City State Zip
Name of Policy Holder
(Insured):____
Last, First M.I.
Policy Holder (Insured) Date of Birth: _____/_____/_____
SS# ____ Sex: __Male __Female
Policy #:____
Group Name or # ____
Policy Type: __HMO __PPO
Employer Name:
____

EmployerAddress:____

**SOUNDS GOOD AUDIOLOGY SERVICES PLLC**
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INSURANCE COVERAGE - SECONDARY:

Insurance Co. Name:____
Phone: (_______)________________________
Address of Claim Center
____
City State Zip
Name of Policy Holder
(Insured):____
Policy Holder (Insured) Date of Birth: _____/_____/_____ SS# ____________Sex: __Male __Female
Policy #:____________________________________Group Name ____________________________
Policy Type: __HMO __PPO
Employer Name:
____
Last First M.I.
EmployerAddress:____
City State Zip

REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name: ____ Today's Date _____/_____/_____
Other family members that are patients
____
Referred by: ____
Primary Care Physician: ____
Phone:______________________________

EMERGENCY CONTACT INFORMATION:

In case of emergency, who should be notified? ______________________ Phone ________________________

Do you give our office permission to discuss your medical information with family members?

__YES __NO / If yes, please provide their names and phone numbers below.
Name:____
Relationship:____
Phone # day __________________________________
Phone # evening ____

May we leave personal medical information on your answering machine at home?

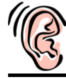
__YES __NO

May we leave personal medical information on your answering machine at work?

__YES __NO

May we email personal medical information to you?

__YES __NO

 **SOUNDS GOOD AUDIOLOGY SERVICES PLLC**
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RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature

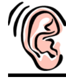
____Date_______________________________

PAYMENT POLICY:

HMO, PPO or other managed care patients: **You will be responsible for paying your annual deductible, copayment and charges for any non-covered services.**
Commercial Patients: Patients who are covered by private, commercial plans in which our physician is not a provider will be required to pay 35% of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.
Patient or Responsible Party Signature

_________________________ ____/____/_____
PATIENT SIGNATURE Date

_________________________ ____/____/_____
Reviewed by Date

SOUNDS GOOD AUDIOLOGY SERVICES PLLC
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HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

Signature: ___________________________________Date: ____________________

Printed Name - Patient or Representative _____________________________________

Relationship to Patient (if other than patient): __________________________________

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OFFICE FINANCIAL POLICY

Patient Name: _________________________________ Date of Birth: _____/_____/_____

We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

1. We are Medicare Participating providers. We will bill Medicare and Medigap carriers. You will be responsible at the time of service for payment of:
    a. The annual deductibles
    b. Copayments
    c. Charges for noncovered services (You will be asked to sign an AdvanceBeneficiary Notice of Liability (ABN) Form in the event that a service is provided which we know is not covered by Medicare.)

2. If you have Medicare, as well as secondary coverage with a commercial plan that is not Medigap or is an insurance company with which we have no contract, we will file a claim to your secondary/supplemental carrier. If no payment is received from your secondary/supplemental carrier within 60 days after we file a claim, you will be sent a bill and will be responsible for the balance. If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for all covered, medically necessary services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible at the time of service for payment of:
    a. The annual deductibles
    b. Copayments
    c. Charges for noncovered services.

In the event that you, as the patient, or we, as the physicians, are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier.

3. For non-Medicare patients who have insurance coverage with an insurance carrier with which we do not have a contractual relationship, please note the following:
    a. We will file both your primary and secondary insurance. If we receive payment from the primary, we will file a claim with your secondary. If we do not receive payment from your primary carrier within 60 days of filing, you will be billed for the entire amount. Payment is due 10 days after receipt of the statement.
    b. If you only have primary insurance (e.g., no secondary/supplemental coverage), you will be asked to pay 100% of the bill on the day of service. This can be done by cash, check, American Express, Discover, MasterCard, Visa. We will still notify your insurer of the visit and the amount that you paid, which may therefore be applied to your deductible, or which may be refunded to you, in all or in part, should the insurer choose to do so based on your particular plan.
    Please understand that since we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefits. Any balance remaining after your primary carrier has paid will be billed to you and is due and payable 10 days after receipt of the statement..

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

_______________________________________ ______________________

Patient signature Date