Abington Audiology & Balance Center

Clarks Summit ● Tunkhannock
570-587-3277

PATIENT INFORMATION

First Name ____________________ Middle Initial _______ Last Name ________________
Address (Street) ____
City _______________________________________ State: __________________ Zip: _______________
Home Phone: __________________ Work Phone: ___________________ Cell: ________________
Birth Date: _______________ Age: ________ Male _____ Female ______
Social Security #__________________ Patient's Occupation: _________
Employer:________________________________Is Patient a full-time student? Yes _____ No _____
Marital Status: Married____ Divorced___ Single____ Separated____ Widowed____
Spouse's Name ___________________ Parent's Name(s) (if pt. is under 18):_______________________
Referred by: ____
Primary Physician: __________________________________ Phone #:__________________________
ENT Physician: _____________________________________ Phone #:___________________________
Emergency Contact: __________________________________ Phone #:__________________________
How did you hear about Abington Audiology & Balance Center (Please check one):
_____Referred by Physician _____Referred by Friend _____Radio Ad (name)
_____Newspaper Ad (name) _____School _____Yellow Pages _____Online _____Other

INSURANCE INFORMATION (PLESAE SUBMIT COPIES)

This area must be completed carefully and entirely for proper submission of your insurance claim. Failure to do so could results in non-payment of your claims.

Primary Insurance: ____
Address: ____
Phone#: _____________Group ID#: __________Insurance ID#: _____________
Primary Cardholder: _______________Birthdate:________ Relationship:_______
Primary Cardholder's employer: ______________ Social Security #: _____________
Address of Cardholder if Different from Patient: ______________________________

Secondary Insurance: ____
Address: ____
Phone #: _________________Group#: ___________ ID# _____________________
Primary Cardholder: ____________Birthdate:__________Relationship: ____________
Primary Cardholder's employer:_________________Social Security #: ____________
Address of Cardholder if Different from Patient: __________________________

SIGNATURE AUTHORIZATION

I authorize Abington Audiology and Balance Center to release information requested with regards to processing my claims.

REGARDING INSURANCE: We may accept assignment of insurance benefits. Your insurance is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance may be billed to you. Please be aware that some, and perhaps all, of the services provide may be non-covered services and not considered reasonable and necessary by the medical insurance.

REGARDING INSURANCE PLANS WHERE WE ARE PARTICIPATING PROVIDERS: All co-pays and deductibles are due prior to service.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the nest service to our patients. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination or usual and customary rates.

Signature: ____ Date: _____________________

Patient Authorization Disclosure:
I wish to be contacted in the following manner (Check all that apply)
Leave a message with: __Detailed information __Call back # only __Do not call me at work __ Written Communication

Acknowledgement of Receipt of Notice:
I acknowledge that I have received and reviewed the Health Insurance & Portability & Accountability Act (HIPAA) policy of this office.

Signature: ____ Date: ______________________