Confidential Case History

smartstep HEARING
Your in-home hearing care professionals.

Today's Date

Legal Name _____ Birthdate _____

Primary Address _____

City _____ State _____ Zip _____

Mailing Address _____

City _____ State _____ Zip _____

Phone Number: Home (____)_____ Cell (____)_____ Work (____)_____

E-mail Address _____ Occupation _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Other _____

Emergency Contact: Name _____ Relationship to Patient _____

Phone _____ E-mail _____

Is someone else responsible for: Financial Decisions? ☐Y ☐N Medical Decisions? ☐Y ☐N

Power of Attorney? ☐Y ☐N Name of responsible party: _____

How did you hear about SmartStep Hearing? _____

INSURANCE

SmartStep Hearing is pleased to participate with many insurance plans and networks. Patients should contact their insurance companies directly to check for network participation and benefit information.

Primary Insurance _____ ID# _____Group Plan _____

Plan or Program Name _____ Phone (_____)_____

Secondary Insurance _____ ID# _____Group Plan _____

Plan or Program Name _____ Phone (_____)_____

PRIMARY PHYSICIAN

Name _____ City _____ Phone (_____)_____

Would you like us to release a copy of your test information to your physician? ☐Y ☐N

_____ Initials

Release Authorization

RELEASE OF PATIENT INFORMATION

Your signature below authorizes your residential community to release certain personal information to SmartStep Hearing. This information may include personal contact information, emergency contact information, insurance details, and medical contacts related to hearing health. A representative from SmartStep Hearing will contact you to confirm services and appointment times.

I request and authorize: _____(name of Residential Community) to release healthcare information for the resident named below to SmartStep Hearing.

_____ PATIENT or RESPONSIBLE PARTY Initials

PRIVACY NOTICE

I have reviewed the SmartStep Hearing Notice of Privacy Practices "the "Notice" and understand that all my medical information will be used by SmartStep Hearing in accordance with the notice. I have been informed that I can request a copy of "the Notice" at any time either by hard copy or email.

_____ PATIENT or RESPONSIBLE PARTY Initials

CONSENT FOR SERVICES AND TREATMENT

I hereby agree to and give consent to any diagnostic testing, rehabilitation or treatment rendered to myself as a patient of SmartStep Hearing and the provider assigned to care for me.

PATIENT Name (print) _____ Birthdate _____

PATIENT Signature _____ Date _____

PATIENT Address _____ Phone _____

Responsible Party Name (print) _____

Responsible for: ☐ Financial Decisions ☐ Medical Decisions

Responsible Party Signature _____ Date _____

Phone_____ Email_____

Please return this form to SmartStep Hearing by fax, secure email, or mail.

Experience the beauty and sounds of everyday life with SmartStep Hearing.

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