Gomer Hearing Center
4101 E. Renner Road, Suite 106
Richardson, TX 75082
Main: 972-803-8072
Fax: 214-238-3806

Allen Hearing Clinic
915 W. Exchange Pkwy, Suite 180A
Allen, TX 75013
972-747-1333 (p)

Welcome to Gomer Hearing LLC, offices of Gomer Hearing Center and Allen Hearing Clinic! We want to provide excellent hearing care to you. Please tell us a little about yourself.

How did you hear about us?_____

PERSONAL INFORMATION

Patient's Name _____

Mailing Address _____ City _____ Zip _____

Telephone: Cell _____ Home _____ Work _____

Birthdate _____ Age _____ Marital Status _____ € Male € Female

Email Address _____ May we contact you via email? € YES € NO

Emergency Contact _____ Relationship _____

Emergency Contact Telephone _____

Name and telephone of primary care physician_____

Please initial **ONE**: _____ Send a copy to my physician _____ ***DO NOT*** send a copy to my physician

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of Gomer Hearing LLC's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, the website (if applicable) and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

- This Notice informs me how Gomer Hearing LLC will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Gomer Hearing LLC may use and share my health information for other than treatment, payment, and health care operations.
- Gomer Hearing LLC will also use and share my health information as required/permitted by law.

_____ _____
Signature Date

RELEASE OF INFORMATION

I give permission to Gomer Hearing LLC to release any information about me, my health, the health services provided to me, or payment for my health services which may be necessary to the people named below:

_____ _____
Name Relationship

_____ _____
Name Relationship

My signature on this authorization indicates that I am giving permission for the uses and disclosures of my protected health information. I hereby release Gomer Hearing LLC, its associated providers, and its employees from any, and all liability that may arise from the release of information as I have directed.

_____ _____

Signature Date

FINANCIAL RESPONSIBLITY

Please read this policy carefully and feel free to ask questions regarding any part of the form. Our goal is to provide you excellent hearing care in a comfortable, personal and cost effective manner. We hope that you will recognize that our financial policies have been developed to maintain this health care service for our patients and for the community, which means lower fees for you. You can help by paying for your care in a timely manner.

Payment

Payment for services is due in full at the time of service. Payments may be made by cash, check, or credit card. Unless other arrangements are approved by us in writing, the balance on your account is due and paid when the statement is issued. If not paid by the end of the month it will be considered past due.

Insurance

In order to bill your insurance company for your hearing care, it is extremely important that we obtain complete information about your primary and supplemental insurance coverage, including phone numbers, addresses, and a copy of your cards. Even though we bill your insurance company for you, we will still collect any office copayments from you at the time of service. We cannot guarantee payment of the benefits and subsequently you may be responsible for any coinsurance, deductibles, or fees for non-covered services that may result

No Show and Cancelled Appointments

We will call the day before your appointment to confirm your attendance. If we don't reach you, we will leave a message. Please give 24 hours' notice if unable to keep an appointment. ***We reserve the right to charge a $25 fee for missed appointments or appointments that are cancelled without 24 hour notice.***

Returned Checks

There is a fee of $35 for any checks returned by the bank.

FINANCIAL AGREEMENT

Once you have signed this document, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

- **I agree to pay promptly all fees and charges for treatments provided to me and/or my family.**
- **I have read the policies above and understand them.**
- **I understand that I am financially responsible for all charges, whether or not they are covered by my insurance.**
- **I authorize Gomer Hearing LLC to release to my insurance carrier any medical information needed to obtain payment for services.**

We will work with you to ensure that your hearing care is the finest available and it does not become a financial burden.

_____ _____

Signature Date