Rehder Hearing Clinic

1101 North 27th St, Ste E
Billings, MT 59101
406-245-6893

Privacy Notice Signed: *Last Updated:*

Patient Information

(if this is an update, please cross out and correct any information that has changed)

Patient's Name _____ (First / Initial / Last) Parent (if child) _____

Address _____

City _____ State _____ Zip Code _____ Work Phone _____

Home Phone _____ Cell Phone: _____ Email: _____

Soc Sec # _____ DOB _____ Marital Status _____ Spouse _____

Place of Employment _____ Age _____ Sex _____ Referral Source _____

Physician's Address _____ Primay Care Physician _____

Primary Insurance Information

(if patient is also the insured, enter 'SAME' for name & address)

Insurance Co. Name _____

Insured's Name _____ (First / Initial / Last)

Patient Relation to Insured _____ Insured DOB _____ Insured Sex _____ Insured SSN _____

Subscriber ID _____ Group Num _____

Secondary Insurance Information

(if patient is also the insured, enter 'SAME' for name & address)

Insurance Co. Name _____

Insured's Name _____ (First / Initial / Last)

Patient Relation to Insured _____ Insured Date of Birth _____

Subscriber ID Num _____ Group Num _____

FINANCIAL RESPONSIBILITY

By signing below, I allow Rehder Hearing Clinic to release all medical information to my insurance carrier(s). I also agree to accept financial responsibility for all charges which are non-covered and thus not paid to Rehder Hearing Clinic by my insurance carrier(s) for services rendered by our office. Balance is due in 90 days from date of service. Any balance left delinquent after 90 days will assigned to third party collections. RHC requires a 24 hour notice of cancellation without acquiring an office charge of $50.

By providing our office with your cell phone, you are giving our office permission to call that phone.

Patient's Representative(s):

This person is a family member or friend who may call our office on your behalf. Unless their name is listed below, we will not be able to speak with them about your medical concerns.

I hereby authorize the following individuals to have access to my healthcare information:

_____, Relationship to Patient _____

_____, Relationship to Patient _____

Would you like to receive communications/marketing from Rehder Hearing Clinic by:
(Circle Yes or No) Phone: Yes No Mail: Yes No Email Yes No

X Signed _____ Date _____
(Patient/Parent or Guardian)