CEI Medical Group
ear • sleep • sinus • face

Today's Date _____

Patient Information

Name _____ Date of Birth _____ Age _____
last name first name m.i.

Address _____
street apt # city state zip

Mailing Address _____
If different than above city state zip

Home Phone (____) _____ Sex: M F Status: S M D W

Additional Information for **PATIENT** or Guardian (Required)

Name of responsible person if other than patient or if patient is a minor _____

Relationship to Patient _____ Date of Birth _____

Home Phone (____) _____ **Work Phone** (____) _____

Cell Phone (____) _____ **E-Mail** _____

Social Security # _____ **Driver's License #/State** _____

Place of Birth _____ **Occupation** _____

Emergency Contact Information

Name of Person to Contact _____

Phone (____) _____ Relationship to Patient _____

☐ Check here to authorize CEI Medical Group to disclose your private health information to this individual

Insurance Information

Primary Insurance

Insurance Co. Name _____
Subscriber Name _____
Subscriber I.D. # _____
Group or Policy # _____
Subscriber Date of Birth _____
Relationship to Patient _____

Secondary Insurance

Insurance Co. Name _____
Subscriber Name _____
Subscriber I.D. # _____
Group or Policy # _____
Subscriber Date of Birth _____
Relationship to Patient _____

How Did You Hear About Us?

Reason for Consultation _____

Referred By _____ Specialty _____

Address _____ Phone (___) _____

Or ☐ Yellow Pages ☐ Relative ☐ Friend ☐ Employee ☐ Event ☐ Other _____

Who is your Primary Care Physician? _____

Address _____ Phone (___) _____

Other

I would like to receive newsletters and/or information about CEI Medical Group events ☐ Yes ☐ No

CEI Medical Group may leave voice mail messages containing my private health Information on any of the phone numbers listed on this form ☐ Yes ☐ No

Language I would prefer reminder phone calls in _____

Patient Signature _____ **Date** _____

GLOBAL HEARING, INC
Hear for Your Future

MASTER AGREEMENT

The following policies and procedures are inclusive of Global Hearing, Inc.

- Medicare / Third Party Payor Agreement Effective 7/15/2009, last updated 1/1/2012
- Patient Email Policy (Effective 2/29/2012)
- Patient Service Guidelines (Effective 1/01/2012, last updated 01/20/2014)

By signing this document, I acknowledge the receipt of and had the opportunity to review the following documents pertaining to my visit to see a Global Hearing service provider and I attest that all of the information I have provided to Global Hearing is true to the best of my knowledge, and that I will notify Global Hearing of any changes. I understand that acceptance of these terms is a condition of receiving care from Global Hearing.

_____
Patient Name (Print) **Date**

_____ _____
Patient Signature **Date** **Witness** **Date**

_____
Title (if signed by someone other than Patient)

www.hearingdevicecenter.com

PALO ALTO
1900 University Avenue, Suite 101
E. Palo Alto, CA 94303
Telephone (650) 494-1000
Fax (650) 322-8228

GLOBAL HEARING, INC
Hear for Your Future

Medicare / Third Party Payor Agreement

Effective 7/15/2009, last updated 1/1/2012

This private agreement made this day, between Global Hearing, Inc., whose principle place of business is 1900 University Ave., Suite # 101 East Palo Alto, CA 94303 and the undersigned private patient for the provision of services by Global Hearing, Inc.

Global Hearing, Inc. and its service providers are not contracted with Medicare or any other government or private insurance carrier and cannot submit claims on behalf of the patient to their insurance company. Payment for services provided by Global Hearing, Inc. to the patient is due in full that day.

The patient agrees and understands that by signing this Agreement they accept the following:

ALL PATIENTS:

_____Patient is not currently facing an emergency or urgent health care situation.

_____Patient agrees and understands that they are responsible to pay in full on the day services are provided by Global Hearing, Inc.

_____Patient agrees and understands that they have the right to choose a service provider other than Global Hearing, Inc. who will accept Medicare and other insurance plans with in network providers to provide their services.

MEDICARE PATIENTS ONLY:

_____Patient agrees and understands that Global Hearing, Inc. is not contracted with the Medicare program or any private insurance carriers and that no Medicare limits, including Medicare charge limits, shall be applicable to the services provided.

____Patient agrees and understands that they may not submit any claim, or request Global Hearing Inc. to submit any claim, for the services provided to the Medicare program.

PATIENTS WITH ANY INSURANCE OTHER THAN MEDICARE INCLUDING MEDICARE SUPPLEMENTALS

____For non-medical services, patient agrees and understands that they are responsible for submitting claims for any potential reimbursement from private (non Medicare) insurers. For medical services, Global Hearing will submit claims for reimbursement on a one-time courtesy basis, and Patient will be responsible for the remaining balance afterwards.

____Patient agrees and understands that neither the Medi-Cal plan nor any supplemental insurance plan shall make payment for services when a payment is not made under the Medicare program.

If this Agreement is being signed by someone other than the Patient, the individual executing the agreement represents and warrants they have the legal authority to execute the agreement on behalf of the Patient.

_____ _____

Patient Signature **Date** **Witness** **Date**

_____

Title (if signed by someone other than Patient)

GLOBAL HEARING, INC
Hear for Your Future

PATIENT E-MAIL TERMS OF USE
Effective 2/29/2012

E-MAIL DISCLAIMER

Global Hearing, Inc (hereinafter "the Clinics") will use reasonable means to protect the privacy of your health information sent by e-mail. However, because of the risks outlined below, the Clinics cannot guarantee that e-mail communications will be confidential. Additionally, the Clinics will not be liable in the event that you or anyone else inappropriately accesses or uses your e-mail. The Clinics will not be liable for improper disclosure of your health information that is not caused by intentional misconduct.

YOUR RESPONSIBILITY TO REDUCE E-MAIL RISKS

At the discretion of the Clinics, its staff, physicians and agents ("Clinic Personnel") and upon your agreement to the terms outlined within this consent form, you may use e-mail to communicate with Clinic Personnel. These e-mails may contain your personal health information. If you decide to use e-mail to communicate with Clinic Personnel you should be aware of the following risks and/or your responsibilities:

1. As the Internet is not secure or private, unauthorized people may be able to intercept, read and possibly modify e-mail you send to or are sent by Clinic Personnel.

2. You are responsible for protecting your e-mail account, password and computer against access by unauthorized people.

3. Since e-mail can be used to spread viruses, some which cause e-mail messages to be sent to people who you do not intend to send e-mail messages to, you should install and maintain virus protection software on your PC.

4. Since e-mails can be copied, printed and forwarded by people to whom you send e-mails, you should be careful regarding whom you send e-mails.

5. As your employer may claim ownership of, or the right to access, the e-mail account issued to you by your e-mail, you should avoid using an employer issued e-mail account to communicate with the Clinics.

TERMS AND CONDITIONS FOR THE USE OF E-MAIL

By consenting to the use of e-mail with the Clinics, you agree that:

1. In consideration of being allowed to communicate with Clinic Personnel using e-mail, you agree that the following actions shall constitute a material breach of these Terms and Conditions:
    a. signing on as or pretending to be another person

b. using secure messaging for any purpose in violation of local, state, national, international laws or posted Clinic policies
c. transmitting material that infringes or violates the intellectual property rights of others or the privacy or publicity rights of others
d. transmitting material that is unlawful, obscene, defamatory, predatory of minors, threatening, harassing, abusive, slanderous, or hateful to any person (including Clinic Personnel) or entity as determined by the Clinics in its sole discretion
e. using e-mail in a way that is intended to harm, or a reasonable person would understand would likely result in harm, to the user or others
f. collecting information about others, including e-mail addresses
g. intentionally distributing viruses or other harmful computer code

2. Clinic Personnel expressly reserve the right, in its sole discretion, to terminate your access to e-mail communication due to any act that would constitute a violation of these Terms and Conditions.

3. Clinic Personnel may forward e-mails as appropriate for diagnosis, treatment, reimbursement, and other related reasons related to your email or the operation of the email system. Your e-mail and our reply will be printed and included as part of your medical record. Therefore, Clinic Personnel, other than your intended recipient, may have access to e-mails that you send. Clinic Personnel will not forward e-mails to independent third parties without your prior written consent, except as authorized or required by law, or for insurance or billing purposes.

4. Although Clinic Personnel will try to read and respond promptly to your e-mails, this response may not be immediate. Therefore, you should not use e-mail to communicate with the Clinics if there is an emergency or where you require an answer in a short period of time.

   If you think you have a medical or psychiatric emergency, call 911 or go to the nearest hospital. Do not attempt to access emergency care through e-mail communication with the Clinics or Clinic Personnel.

5. If your e-mail requires or asks for a response, and you have not received a response within a reasonable time period, it is your responsibility to follow up directly with Clinic Personnel by telephone.

6. You should carefully consider the risk of using e-mail for the communication of sensitive medical information, such as, but not limited to, information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.

7. You should carefully word your e-mail messages so the information provided clearly, yet briefly, describes the information you intend to convey. You should avoid writing long "chatty" e-mails.

8. You are responsible for correcting any unclear or incorrect information.

9. It is your responsibility to follow up and/or schedule an appointment if warranted or recommended by Clinic Personnel.

10. E-mails may not be the only form of communication that the Clinics will use to communicate with you. Additionally, Clinic Personnel may decide that it is not in your best interest to continue to communicate with you by e-mail. In such case, the Clinic will notify that it no longer intends to communicate with you by e-mail.

GLOBAL HEARING, INC
Hear for Your Future

Patient Service Guidelines

Effective 1/1/2012

Consent to Treatment: I voluntary request and authorize Global Hearing, Inc to render care, including diagnostic procedures and medical treatment, by its authorized agents and employees (collectively, "Clinic Personnel"). I acknowledge that no guarantees have been made as to the efficacy of such examination of treatment for my condition, or the condition of the person on whose behalf I am legally authorized to consent to (collectively, the "Patient"). I understand that I have the right to make decisions concerning the Patient's health care, including the right to authorize or refuse medical and surgical procedures.

Release of Information: By signing this document, the Patient is authorizing release of the Patient's medical records under the following circumstances: Please also note that per California Law there will be a fee to provide you with a copy of your medical records.

1. To any health, sickness, and accident insurance carrier, workman's compensation insurers, or any governmental agency which is legally responsible, or which the Clinics have good cause to believe is legally responsible for all or any part of the Clinics charges and/or professional fees;
2. To physicians or health care facilities rendering professional care to the Patient;
3. To any governmental organization responsible for reviewing medical care;
4. To Clinic Personnel, from physicians or health care facilities rendering professional care to the Patient; or
5. To the CEI Medical Group business entity Clinic Personnel rendering professional care to the Patient.

Cancellation/Missed Appointment Policy: All patients who fail to arrive for their scheduled appointments or who cancel with less than one business day advance notice will be charged a missed appointment fee. This fee applies to all patients, regardless of their insurance status or insurer. **Reminder phone calls are a courtesy, and the lack of receipt of a reminder call is not a valid excuse for missed appointments.** Missed appointment fees are NOT covered by insurance, and will be the Patient's personal responsibility to pay. You will not be able to make future appointments until any outstanding missed appointment fees are paid. Missed appointment fees are as follows:

New Patient Medical Visit	**$75**

All other visits (return medical visit)	**$50**
Audiology/Hearing aid appt	**$50 for every ½ hour scheduled**

If you miss three appointments, we will cancel any remaining appointments and notify the Patient's referring physician.

Payment Guarantee: Patient agrees to be responsible to the Clinics for all charges resulting from services rendered at their prevailing rates. Patient agrees all bills are due in full upon demand. Should Patient fail to honor this agreement, they agree to pay any collection cost or attorney fees resulting from the collection of my accounts. Patient authorizes the use of all information provided to the Clinics in the Patient Registration form for collection purposes. No granting of extensions or delays on the part of the Clinics in enforcing any of their rights shall in any manner release the undersigned liability. Bad checks will be collected pursuant to California Civil Code § 1719 which allows for up to treble damages.

Insurer Billing: Global Hearing does not contract with any insurers. For hearing devices, repairs. and audiology services, payment for Global Hearing Services is expected the date the service is rendered. For medical appointments, a $95 deposit towards the total cost of the medical appointment is due the date of the visit. The Global Hearing billing department will file a claim with your insurer on your behalf at the time of service to assist you with reimbursement on your claim. You will be responsible for any remaining balance not paid by your insurance.

Assignment of Benefits: I hereby assign all rights and privileges and authorize payment directly to Global Hearing for any claim filed on the Patient's behalf. I agree this assignment is primary to any assignment given after this date including any cost relative to attorney fees. I also understand that I am financially responsible to the Clinics for charges not covered by this assignment or not paid on a timely basis by the insurance company. **FOR ALL TYPES OF CLAIMS *OTHER THAN MEDICAL SERVICES*, because Global Hearing is not contracted with any insurer and requires cash payment at the time of service, any amounts paid by the insurer should go directly to the Patient. Medical services are first reimbursed to Global Hearing, and any amounts overpaid are then sent by refund check by Global Hearing to the Patient.**

Arbitration: Any dispute, claim or controversy arising out of or relating to this Agreement or the breach, termination, enforcement, interpretation or validity thereof, other than the collection of an amount due on a returned check, including the determination of the scope or applicability of this agreement to arbitrate, shall be determined by arbitration in Palo Alto, CA, before an arbitrator. The arbitration shall be administered by the American Arbitration Association (AAA) pursuant to the AAA's Rules and Procedures. Judgment on the award may be entered in any court having jurisdiction. This clause shall not preclude parties from seeking provisional remedies in aid of arbitration from a court of appropriate jurisdiction. The arbitrator may, in the award, allocate all or part of the costs of the arbitration, including the fees of the arbitrator and the reasonable attorneys' fees of the prevailing party.

Assistant Surgeon: For the Patient's benefit, Clinic Personnel may elect to have an assistant surgeon present at the time of surgery. The assistant surgeon may be a physician, physician's assistant, or nurse practitioner. The usual fee for the assistant surgeon is 25 % of the surgeon's fee. Some insurance carriers do not provide benefits for assistant surgeons. If the patient's insurer denies coverage, the fee will be reduced to $250, but it will be immediately due and payable in full.

Image Recording: I understand that CEI Medical Group is a teaching institution, and that my office visits may be recorded and used for training, educational, or publication purposes. This recording will be anonymous and you will not be identified, or identifiable. I hereby release and hold harmless the CEI Medical Group, its Boards of Directors, officers, administrators, employees, and producers from any and all liability in connection with the production, distribution, and marketing, including but not limited to retail sales of the digital resources, in whatever form and through whatever media. I cede any and all rights, title, and interest in the digital resources to which I may be entitled by law to CEI Medical Group, and agree to make no claim for compensation for the uses of my image in the production, distribution, marketing, and/or other activities related to the digital resources.

CT Scan: I understand that CEI Medical Group holds an ownership interest in the CT scan equipment on site. I understand that a CT scan is ordered, I may chose to utilize this equipment, or I have the option to choose a different facility to have the CT scan completed. I have been provided with a list of alternate CT facilities. If I choose the CEI Medical Group CT machine, CEI Medical Group is responsible for obtaining the insurance authorization. I understand that if I choose to have my CT scan completed at an alternative facility that CEI Medical Group is not responsible for obtaining the CT authorization from my insurance carrier. Additionally, I may also be responsible for signing a medical records release for obtaining the CT records for Dr. Roberson to review and I am solely responsible for paying any fees associated with that records release.

Phone and Email Consults: I understand that Global Hearing and the CEI Medical Group may consult conduct phone consults. These consults may result in a fee. This fee will be discussed prior to scheduling.