AUDIOLOGY ASSOCIATES, INC.
Patient Registration

Please complete this packet and bring to your appointment along with insurance card(s) and photo ID. Referrals and co-pays are due at the time of visit.

Patient Name: _____ Date of Birth: _____
Social Security #_____ (not applicable under 18) Male:___ Female: ___
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Alternate Phone: _____
E-mail Address: _____
Patient Employer: _____ Phone: _____
Employer Address: _____
City: _____ State: _____ Zip: _____

Person Responsible for Payment: _____
Driver's License #: _____ SS #: _____

Emergency Contact: _____ Relationship: _____
Phone: _____ Alternate Phone: _____

Primary Insurance: _____ ID #: _____
Group #: _____

Secondary Insurance: _____ ID #: _____
Group #: _____

Subscriber's Name: _____
Subscriber's Date of Birth: _____ SS#: _____
Relationship to Patient: _____

Subscriber's Employer: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____

Whom may we thank for referring you? _____

Primary Care Doctor: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Report also to: _____

PLEASE READ AND SIGN THE FINANCIAL POLICY ON THE BACK OF THIS FORM.

AUDIOLOGY ASSOCIATES, INC.
Financial Policy

Thank you for choosing us as your hearing healthcare provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

COPAYMENTS are due at time of visit.
MEDICARE requires a physician's order for all audiology services.
REFERRALS are due at time of visit.
We accept CASH, CHECKS, VISA, MASTERCARD, & DISCOVER
MISSED or cancelled appointments without 24-hour notification will incur a $25 fee.
All REFUNDS are issued via check.

Regarding Insurance
Your insurance policy is a contract between you and your insurance company. Please be aware that some and perhaps all of the services rendered may be a non-covered benefit under your plan's policy and therefore your responsibility. Please check with your insurance carrier. We are participating providers with most insurance carriers. If your insurance company has not paid your claim within 60 days, this office will notify you. If you belong to an HMO or POS it is your responsibility to obtain a referral from your primary physician's office. If you are seen **without a referral**, payment will be due at the time of service.

Usual and customary
Our practice is committed to providing the best hearing healthcare for our patients, and we charge what is usual and customary for our area. For insurance carriers not contracted with us, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Past Due Accounts
Any accounts past due after 90 days will be forwarded to our collection agency. A 30% collection agency fee, court costs and attorney fees will be assessed.

Check Return Policy
Returned checks may be assessed up to a $20.00 service charge (per resubmit to bank).

I authorized release of information to **primary/secondary insurance companies.**
I understand that I am responsible for my bill **(Both parent(s) and/or legal guardian(s) are responsible for the minor's bill)**.
I authorize payment directly to Audiology Associates, Inc.
I permit a copy of this authorization to be used in place of an original.

I have read the policy above and understand and agree to terms as listed.

X_____ Date_____
(Signature of pt or responsible party)

X_____ Date_____
(Signature of co-responsible party)

Please let us know if you have any questions regarding this policy.

Revised 03/30/2016

Melissa J. Segev, Au.D., F.A.A.A.
Briana Bruno Holtan, Au.D., F.A.A.A.
Christina Bradford, Au.D., F.A.A.A.
Arifa Gir, Au.D., F.A.A.A.
Charlotte Godfrey, Au.D., F.A.A.A.

Audiology Associates
INCORPORATED
aaiaudiology.com

Aimee Kaplan, Au.D., F.A.A.A.
Jessica Verni, Au.D., F.A.A.A.
Corinne Richards, Au.D., F.A.A.A.
Anne Rouleau, Au.D., F.A.A.A.

Child History Form

DATE: _____

Name: _____ DOB: _____

Contact: _____ Phone #: _____

1. Medical illness or syndrome? ☐ Yes ☐ No
   Please explain: _____
2. Do you suspect hearing loss? ☐ Yes Which ear? _____ ☐ No
3. Pain from ears? ☐ Yes Which ear? _____ ☐ No
4. History of middle ear infections? ☐ Yes ☐ No
   Date of last middle ear infection: _____
5. History of PE tubes? ☐ Yes When? _____ ☐ No

6a. Sinus problems? ☐ Yes ☐ No 6b. Allergy problems? ☐ Yes ☐ No

7. Recent colds? ☐ Yes When? _____ ☐ No
8. Medications-please list: _____
9. Family history of hearing loss? ☐ Yes Who? _____ ☐ No
10. Birth or delivery complications? ☐ None ☐ Jaundice ☐ Premature ☐ Illness ☐ NICU ☐ Ventilator ☐ Other _____
11. Previous hearing screening evaluation results: _____
12. Speech/Language Delays? ☐ Yes ☐ No
13. Developmental Delays? ☐ Yes ☐ No
14. School Performance? ☐ Below Average ☐ Average ☐ Above Average
15. Early intervention, speech or other therapy? ☐ Yes Which? _____ ☐ No
16. Diagnosis for Attention Deficits? ☐ Yes ☐ No

Infants Only

17. Responsiveness to Auditory Stimuli? ☐ Yes ☐ No
18. Localization Abilities? Does he/she look for the source of sounds? ☐ Yes ☐ No
19. Does he/she startle to loud noises? ☐ Yes ☐ No

Additional comments: _____

Primary Care Physician: _____ Phone: _____

Address: _____

1/27/2016

Audiology Associates, Inc.
Health Information Privacy and Affordability Act (HIPAA) Packet

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Social Security #: _____ Phone #: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

- This Notice informs me how Audiology Associates Inc. will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Audiology Associates Inc. may use and share my health information for other than treatment, payment, and health care operations.
- Audiology Associates Inc. will also use and share my health information as required/permitted by law.
- I acknowledge that I received a copy of Audiology Associates Inc.'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 if amended.

AUTHORIZATION TO USE AND DISCLOSURE OF HEALTH INFORMATION

I request and authorize Audiology Associates Inc. to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

Choose one option:

___ I consent to Audiology Associates Inc. releasing protected health as detailed below.

If applicable, please list names of family or personal representatives whom we may disclose information to in the event you are unable to contact us directly for any related Audiological questions or needs pertaining to your care and/or financial related issues.

_____

_____

___ I prohibit Audiology Associates Inc. from using and disclosing medical information to any person or entity other than required by HIPAA regulations.

Continue to Page (2)

AUTHORIZATION AND RELEASE FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR MARKETING

___ **Please check here if you <u>authorize</u> Audiology Associates Inc. to use or disclose your protected health information for marketing related products or services.** I understand that Audiology Associates Inc. or its business associates may receive financial remuneration in exchange for making the marketing communication on behalf of the third party whose product or service is being described. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

I authorize Audiology Associates Inc. to use and disclose my protected health information as set forth above. I understand that this authorization is voluntary and that Audiology Associates Inc. cannot condition my treatment, services, etc., on the signing of this authorization. **I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.** This authorization will expire (1) one year from the date it is signed.

Printed name of patient or personal representative

_____ Date: _____

Signature of patient or personal representative

_____ Date: _____

<u>Revocation Section</u>

<u>Right to Revoke</u>: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation. I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Audiology Associates Inc. at the address listed below.

Only sign the revocation section below if you wish to revoke all prior authorizations regarding the use and disclosure of your health information:

Revocation: _____ Date: _____

If you have any questions or need assistance in completing this authorization form, please contact **Donna Trostle, at (410) 646-3100.**

Audiology Associates, Inc.
9613-I Harford Road
Baltimore, MD 21234