



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.

First Name: _____ **MI:** ___ **Last Name:** _____

Date of Birth: _____ **Nickname/Preferred Name:** _____

Parent/Guardian Full Name(s): _____

Social Security # _____ **(not applicable under 18)** **Male:** **Female:**

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Alternate Phone:** _____

E-mail Address: _____

Patient Profession: _____

Patient Employer: _____ **Phone:** _____

Employer Address: _____

City: _____ **State:** _____ **Zip:** _____

Emergency Contact: _____ **Relationship:** _____

Phone: _____ **Alternate Phone:** _____

Person Responsible for Payment: _____

Driver's License #: _____ **SS #:** _____

Primary Insurance: _____ **ID #:** _____

Group #: _____

Secondary Insurance: _____ **ID #:** _____

Group #: _____

Subscriber's Name: _____ **Relationship:** _____

Subscriber's Date of Birth: _____ **SS#:** _____

Address if different from patient: _____

Subscriber's Employer: Same as above _____

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**
INCORPORATED
AUDIOLOGY ASSOCIATES, INC.
Financial Policy

Name: _____ **Date of Birth:** _____

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. All co-pays, co-insurances, and deductibles that you have will be billed to you as indicated by your insurance.
MEDICARE requires a physician's order for all audiology services.
REFERRALS are due at time of visit.
We accept CASH, CHECKS, VISA, MASTERCARD, DISCOVER, & AMERICAN EXPRESS.
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 make sure that you understand your insurance policy.** 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. All co-pays, co-insurances, and deductibles that you have will be billed to you as indicated by your insurance. 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**, you may be responsible for the full cost of the visit and 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.



Health Information Privacy and Affordability Act (HIPAA) Packet
Page 1 of 2

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.** *Please note that this section is not valid unless page 2 has been signed by the patient or their authorized representative.*

If applicable, please list names of family and/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 authorize 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 on pages 1 and 2 of this packet. 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: _____

Revocation Section

Right to Revoke: 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 Jaime Lee Fritze, at (410) 944-3100**.**

Audiology Associates, Inc.
7113 Ambassador Road
Baltimore, MD 21244

Adult History Form

DATE: _____

NAME: _____

DOB: _____

1. How long have you had difficulty hearing, if any? _____
2. Better ear? Right Left Same
3. Pain from ears? Yes Which ear? _____ No
4. Any blocked feeling? Yes Which ear? _____ No
5. Facial numbness? Yes No
6. Ringing or noises in ears? Yes Which ear? _____ No
7. Have you worn hearing aids? Yes How long? _____ No
8. Do you have any dizziness? Yes How long? _____ No
9. History of ear surgeries/PE tubes? Yes No
10. Family history of hearing loss? Yes Who? _____ No
11. Worked around or been exposed to loud noises? Yes Where? _____ No
12. Have you had any recent colds? Yes When? _____ No
13. A) Do you have sinus problems? Yes No 13. B) Do you have allergy problems? Yes No
14. History of depression? Yes No
15. Do you have a pacemaker? Yes No
16. Health Problems? Diabetes Heart Circulatory Head Injury Head or neck surgery
 Radiation/Chemotherapy Other _____

17. Medications? Include any over the counter medications, vitamins, herbals, supplements, homeopathic remedies.

<u>Medications</u>	<u>Dose</u>	<u>Frequency</u>	<u>Method</u>	<u>Medical Condition</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

****Please use back of this form if additional space is needed to list medications****

18. Known allergies? Please list: _____
 19. Last surgery date? _____ Procedure: _____
 20. Last hospitalization date? _____ Reason: _____
 21. Use of alcohol? Yes No
 22. Use of tobacco one or more times in the last 24 mos (cigarettes, cigars, smokeless tobacco)? Yes No
- Additional comments: _____
- Primary Care Physician: _____
- Phone: _____ Fax: _____
- Address: _____
- Report also to: _____

Hearing Health Quick Test

1. Do you find it difficult to follow a conversation in a noisy restaurant or crowded room?
 Yes No Sometimes
2. Do you sometimes feel that people are mumbling or not speaking clearly?
 Yes No Sometimes
3. Do you experience difficulty following dialog in the theater?
 Yes No Sometimes
4. Do you sometimes find it difficult to understand a speaker at a public meeting or a religious service?
 Yes No Sometimes
5. Do you find yourself asking people to speak up or repeat themselves?
 Yes No Sometimes
6. Do you find men's voices easier to understand than women's?
 Yes No Sometimes
7. Do you experience difficulty understanding soft or whispered speech?
 Yes No Sometimes
8. Do you have difficulty understanding speech on the telephone?
 Yes No Sometimes
9. Does a hearing problem cause you to feel embarrassed when meeting new people?
 Yes No Sometimes
10. Do you feel handicapped by a hearing problem?
 Yes No Sometimes
11. Does a hearing problem cause you to visit friends, relatives, or neighbors less often than you would like?
 Yes No Sometimes
12. Do you experience ringing or noises in your ears?
 Yes No Sometimes
13. Do you hear better with one ear than the other?
 Yes No Sometimes
14. Have you had any significant noise exposure during work, recreation, or military service?
 Yes No
15. Have any of your relatives (by birth) had a hearing loss?
 Yes No

Scoring

2 points for Yes

1 point for Sometimes

0 points for No

Scores of 3 or more: May mean that you have a hearing problem.

Scores of 6 or more: Strongly suggest that a hearing check is warranted.

If you think you may have a hearing loss, visit www.HowsYourHearing.org and click on the "Find an Audiologist" link to locate and set up an appointment with an audiologist in your area to get your hearing checked.