## 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:** ________________________________________________
________________________________________________

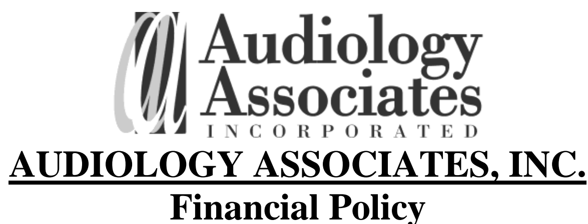
**Subscriber's Employer:** ❑**Same as above** _________________________________________
**Address:** ________________________________________ **Phone:** _______________________
**City:** ____________________________________ **State:** _________ **Zip:** ________________

**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.**

Revised 01/18/2018




# 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.

Revised 01/18/2018

# 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.** *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

## 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: ____________________

Updated 01/18/2018