Melissa J. Segev, Au.D.
Briana Bruno Holtan, Au.D.
Mikayla Abrams, Au.D.
Lori Adams, Au.D.
Deirdre Courtney, Au.D.
Aimee Kaplan, Au.D.

aaiaudiology.com

Jennifer Kincaid, Ph.D.
Corinne Richards, Au.D.
Lindsay Dennison, Au.D.
Sofia Roller, Au.D.
Maeve Salanger, Au.D.
Kayla Volpe, Au.D.

Patient Registration

Revised 02/18/2020

Please complete this registration packet and bring to your appointment along with insurance cards and photo ID. Referrals and co-payments are due at the time of your visit.

First Name: ______________________________ MI: ___ Last Name: ________________________________
Date of Birth: ____________________ Nickname/Preferred Name: ___________________________________
Parent/Guardian Full Name: ____
Social Security #: _______________________ (not applicable under 18) Male: ☐ Female: ☐
Address: ____
City: ____ State: _________ Zip Code: _______________
Home Phone: __________________________________ Cell Phone: ___________________________________
Email Address: ____

Whom may we thank for referring you? ____

Patient's Profession: ____
Patient's Employer: ____ Phone: _________________________
Employer Address: ____

Emergency Contact: ____ Relationship: ______________________
Phone: ____ Alternate Phone: ______________________________

Person Responsible for Payment: ____
Driver's License #: ____ SS#: ___________________________

ALL INFO REQUIRED IN ADDITION TO COPY OF CARD(S)
Primary Insurance: ___________________ ID #: _________________________ Group #: ______________________
Secondary Insurance: __________________ ID #: _________________________ Group #: _______________
Is the patient the insurance subscriber? ( ) YES – Skip to physician info ( ) NO – Please complete info below:
Subscriber's Name:_______________________________________ Relationship: ____________________
Subscriber's DOB: _________________________________ SS#: ____
Address if different from patient: ____
Subscriber's Employer: ____
Employer Address: ____
City: ____ State: _________ Zip Code: _______________

Primary Care Physician: ____
Address: ____
Phone: ____ FAX: ____________________________________
Other relevant physicians (i.e. ENT, Neurologist): ____
Do we have your permission to send a report to the physician(s) listed above (recommended): ☐ Yes ☐ No

PLEASE READ, COMPLETE, AND SIGN THE PRIVACY AND FINANCIAL POLICY FORMS INCLUDED IN THIS PACKET

Melissa J. Segev, Au.D.
Briana Bruno Holtan, Au.D.
Mikayla Abrams, Au.D.
Lori Adams, Au.D.
Deirdre Courtney, Au.D.
Aimee Kaplan, Au.D.

aaiaudiology.com

Jennifer Kincaid, Ph.D.
Corinne Richards, Au.D.
Lindsay Dennison, Au.D.
Sofia Roller, Au.D.
Maeve Salanger, Au.D.
Kayla Volpe, Au.D.

Child History Form

Revised 2/18/2020

Patient Name: ___________________________ DOB: ___________ Today's Date: ___________

Person Completing Form: __________________________________ Relation to Child: _______________

1. Why are we seeing your child today? ____
2. Do you suspect hearing loss? ☐ Yes Which ear? ______________ ☐ No
3. Does your child have any medical issues or syndromes? ☐ Yes ☐ No
   a. Please explain: ____
4. Does your child have any other diagnosed co-morbidities? ☐ Yes, Explain _______________________ ☐ No
(Ex: attention deficit disorder, auditory processing disorder, dyslexia, autism spectrum disorder, etc)
5. Referred due to failed hearing screening at hospital, pediatrician's office, school? ☐ Yes ☐ No
   a. Which ear? ______________________
6. Pain or tugging from ears? ☐ Yes Which ear? __________ ☐ No
7. History of middle ear infections? ☐ Yes Treated with: ☐ Medication ☐ PE Tubes ☐ No
8. Date of last middle ear infection: ______________________________ Which ear(s): ____________________
9. History of PE tubes? ☐ Yes When? _____________ Which ear(s): _________________ ☐ No
10. Sinus problems? ☐ Yes ☐ No 7b. Allergy problems? ☐ Yes ☐ No
11. Recent cold or influenza? ☐ Yes When?____________ ☐ No
12. Medications-please list: ____
13. Family history of childhood (non-age-related) hearing loss? ☐ Yes Who?________________ ☐ No
14. Birth or delivery complications? ☐ None ☐ Jaundice ☐ Premature ☐ Illness

    ☐ NICU ☐ Ventilator ☐ C-Section ☐ Other _________________
15. a. Hospital or place of birth? ____________________________ b. Full-term? ☐ Yes ☐ No
16. Previous hearing screening evaluation results: ____
17. Other significant medical history or diagnoses? ☐ Yes ☐ No _____________________________________

PLEASE CONTINUE TO NEXT PAGE & ANSWER QUESTONS CORRESPONDING TO CHILD'S AGE GROUP

Melissa J. Segev, Au.D.
Briana Bruno Holtan, Au.D.
Mikayla Abrams, Au.D.
Lori Adams, Au.D.
Deirdre Courtney, Au.D.
Aimee Kaplan, Au.D.

aaiaudiology.com

Jennifer Kincaid, Ph.D.
Corinne Richards, Au.D.
Lindsay Dennison, Au.D.
Sofia Roller, Au.D.
Maeve Salanger, Au.D.
Kayla Volpe, Au.D.

Infants Only (age 0 to 3)

1. Responsiveness to Auditory Stimuli? ☐ Yes ☐ No

2. Localization Abilities? Does he/she look for the source of sounds? ☐ Yes ☐ No

3. Does he/she startle to loud noises? ☐ Yes ☐ No

4. At which age (months/years) did he/she achieve the following milestones?

Sitting Up _____________ Crawled _____________ Walked _____________ First Word(s)_____________

Children Only (age 4 to 10)

1. Speech/Language Delays? ☐ Yes ☐ No

2. Developmental Delays? ☐ Yes ☐ No

3. School/Academic Performance? ☐ Below Average ☐ Average ☐ Above Average

4. Diagnosis for Attention Deficits? ☐ Yes ☐ No

5. a) Early intervention, speech or other therapy? ☐ Yes ☐ No

5. b) Describe the therapy/intervention/frequency: ____

Adolescents Only (age 10 and up)

1. Ringing or noises in ears? ☐ Yes Which ear(s)? ____________ How long? ______________ ☐ No

2. Speech/Language Delays? ☐ Yes ☐ No

3. Developmental Delays? ☐ Yes ☐ No

4. School/Academic Performance? ☐ Below Average ☐ Average ☐ Above Average

5. a) Early intervention, speech or other therapy? ☐ Yes ☐ No

   b) Describe the therapy/intervention/frequency: ____

6. Noise exposure without hearing protection and/or use of earphones regularly ☐ Yes ☐ No

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

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 in not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

____ I consent to mailings of birthday cards and/or reminder cards (initial if yes).

PLEASE INITIAL NEXT TO ONE OPTION BELOW:

_____ OPTION 1:	____ OPTION 2:
I consent to Audiology Associates Inc. releasing protected health information as detailed below. Please list names of **FAMILY or PERSONAL REPRESENTATIVES** we may disclose information to in the event that you are unable to contact us directly for any related Audiological questions or needs pertaining to you care and/or financial issues. ____ ____ ____	I **prohibit** Audiology Associates from using and disclosing medical information to any person or entity other than required by HIPAA regulations. If this option is initialed, your doctor will not receive a copy of your report and we may not discuss your care with any family members or personal representatives.

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

______ Please initial here only 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 of 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, service, 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 of personal representative Date of Birth

____ _________________
Signature of patient or personal representative Date Signed

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 those 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 mu 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 Signature: ____ Date: ______________________

Audiology Associates, Inc.
3615 E. Joppa Road, Suite 200
Parkville, MD 21234

Melissa J. Segev, Au.D.
Briana Bruno Holtan, Au.D.
Mikayla Abrams, Au.D.
Lori Adams, Au.D.
Deirdre Courtney, Au.D.
Aimee Kaplan, Au.D.

aaiaudiology.com

Jennifer Kincaid, Ph.D.
Corinne Richards, Au.D.
Lindsay Dennison, Au.D.
Sofia Roller, Au.D.
Maeve Salanger, Au.D.
Kayla Volpe, Au.D.

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

COPAYMENTS are due at the time of visit. MEDICARE requires a physician's order for all audiology services. REFERRALS are due at the time of visit. We accept CASH, CHECKS, VISA, MASTERCARD, DISCOVER, and 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 therefor will be your responsibility. All co-pays, deductibles, and co-insurances that you have will be billed to you as indicated by your insurance company.** We are participating providers with most insurance carriers. If your insurance company ahs not paid your claim within 60 days, this office will notify you. If you belong to an HMO, MCO, or POS, it is your responsibility to obtain a referral from your primary care 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

Audiology Associates, LLC will file your claim with your insurance, if we participate with your insurance; otherwise, payment is required in full for all services at the time they are rendered. You are responsible for all charges not covered by your insurance company. All co-payments and deductibles are to be paid in full within 90 days of your first statement being generated. Unpaid balances after 90 days will incur a $5.00 statement fee. Unpaid balances that are turned over to an external collection agency will incur a fee of 25% of the amount due on the account. You are responsible for all legal fees if your account is turned over to a lawyer for collection. Your signature below signifies your understanding and willingness to comply with this policy.

Check Return Policy

Returned check may be assessed up to a $20.00 service charge (per resubmit to bank).

I authorize the release of information to primary/secondary insurance companies.
I understand that I am responsible for my bill (Both parent(s) and 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 list.

____________________________________ _________________________
Signature of Responsible Party Date

____________________________________ _________________________
Signature of Co-Responsible Party Date