(((The Hearing Center)))

New Patient Information

Name: _____DATE: _____

Address: _____

Date of Birth: _____ Home Phone: _____ Cell Phone: _____

Work Phone: _____ Marital Status (circle One) S M D W

RESPONSIBLE FOR BILLING (circle one) Self/parent/other

Name: _____ DOB: _____

Address: _____

Work Information:

Employer: _____

Address: _____

Insurance Coverage (insurance card must be present at the time of visit)

Primary Insurance:

Insurance Company: _____ Insurance ID: _____

Group #_____

Cardholder Name: _____ DOB: _____

Secondary Insurance:

Insurance Company: _____ Insurance ID: _____

Group # _____

Cardholder Name: _____ DOB: _____

Name of Physician: _____ Report Requested: (Y N)

All professional services rendered are charged to the patient, necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize the release of any medical information necessary to my insurance company for the processing f my claims.

DATE: _____ SIGNATURE: _____

(((The Hearing Center)))
Pediatric Case History

Name of patient:_____Date:_____

Address:_____ Date of

Birth:_____ Age:_____ Gender:_____

Patient's pediatrician and phone: _____

Patient's School and phone:_____Grade:_____

Reason for visit:_____

Suspicion of hearing loss? Why? _____

_____Previous Hearing Test

Date and Results: _____

_____

Hearing Aid Make/Model/Date of Fitting (if applicable) _____

_____

<u>Medical History (Circle all that apply)</u>

Complications during Pregnancy ☐ Complications during Delivery ☐

Failed Newborn Hearing Screen ☐ Speech/Language Delay ☐

Other Developmental Delays ☐ Enrolled in Early Intervention ☐ History

of hearing loss in family ☐ Ear infections/Ventilation Tubes ☐

Other Illnesses/hospitalizations ☐

Please explain:

_____

_____

_____

_____

Informed Consent

Audiological services during Covid-19 Pandemic

Thank you for your continued trust in our practice. AS with the transmission of any communicable disease, such as the cold or flu, you may be exposed to Covid-19, the disease caused by the coronavirus. Rest assured that we have always followed universal recommendations for infection control and prevention, and will currently be following CDC guidelines to limit transmission of all disease through the use of vigorous disinfection protocols and PPE.

Despite our careful attention and best efforts, there is still a chance that you could be exposed to an illness in our office, just as you might be at your grocery store, a gym, or any other public facility. Social distancing has been demonstrated to be a successful means of limiting disease transmission, and we will be utilizing social distancing to the extent that is feasible, though there are times that it is not possible to maintain social distancing.

Although exposure is unlikely, do you accept the risk and consent to treatment.

___ Yes ___ No

_____ _____

Patient/Guardian/POA Signature (Hand or E-signature) Date

Audiology The Hearing Center

Covid-19 Health Questionnaire

If you have been exposed to a communicable disease, you may spread the disease to the Audiologist, staff, or other patients at the practice. We are asking the following questions to reduce the likelihood of disease transmission.

Do you, your family members, care-givers, any members of your household, or anyone you have been in recent contact with have any of the following symptoms?

Fever (above 99.6 degrees)	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Shortness of breath and/or trouble breathing	☐ Yes	☐ No
Pain, pressure, or tightness in the chest	☐ Yes	☐ No
Loss of sense of smell or taste	☐ Yes	☐ No
Skin Rash	☐ Yes	☐ No

Have you been to any state or country on a restricted travel list in the past 3 weeks, including but not limited to (AL, AR, AZ, FL, NC, SC, WA, UT, and TX).

☐ Yes ☐ No

Have you, your family members, care-givers, any members of your household, or anyone you have been in recent contact with tested positive for or been diagnosed as having Covid-19 or any other communicable disease? ☐ Yes ☐ No

If yes, what was the date of diagnosis?_____

_____ _____

Patient/Guardian/POA E-Signature or handwritten Date

(((The Hearing Center)))

OFFICE POLICIES

1. All patients will be asked to produce a valid photo ID at the time of their appointment. If you have had an appointment within the last six months, this requirement will be waived. If not, the staff will verify your current information and if appropriate, require you to complete a new patient registration form.
2. All payments and CO-payments are due before services are rendered. We cannot bill you for co-payments. We accept check, cash, credit cards (Visa, Mastercard, Discover, Amex). The patient/guarantor is responsible for all payments regardless of insurance coverage.
3. If your health insurance requires a referral, it is your responsibility to obtain a referral from your primary care physician prior to your appointment. If you do not have a referral at the time of your appointment, you are responsible for payment as your insurance company may not pay for your visit without a referral.
4. Patients with outstanding account balances will be notified 10 days prior to submission to collection. Accounts that go into collection will be subject to a 35% collection charge. Accounts with balances that exceed 60 days will be subject to a late fee of $10.00, which will then be added to the account balance every 30 days thereafter.
5. There is a $35 charge for returned checks
6. It is your responsibility to notify our office of any name changes or changes in address, phone numbers, or insurance coverage. We need this information to bill your insurance company, and in the event that we have outdated information, any accumulated account balances will be your responsibility.
7. Patients under the age of 18 must be accompanied by an adult.

Patient Signature: _____

Guardian Signature: _____

Printed Name: _____

Privacy Practices Acknowledgement

Patient Name:_____

Please fill out the following information sign and date below.

The Hearing Center **may** leave private health information, on an answering machine or voice mail, regarding the above named patient.

Please list phone numbers where we may contact you or leave messages:

HOME:_____

WORK:_____

CELL:_____

EMAIL:_____

List people or family members with whom we may leave private health information.

_____relationship_____

_____relationship_____

_____relationship_____

I have been provided an opportunity to review the Notice of Privacy Practices.

Signed_____ Date_____