THE HEARING & BALANCE CENTER, INC.

Please fill out the registration to the best of your knowledge.
All patient information is confidential.

Patient First Name: _____ M.I.:_____ Last Name: _____

Date of Birth: _____ SSN: _____ Sex: Female Male

Street: _____ City: _____

State: _____ Zip: _____ Home Phone #: (____) _____ Cell Phone #: (_____) _____

Email Address: _____

Marital Status: _____ Employer: _____ Work Phone #: (_____) _____

Emergency Contact: _____ Relationship: _____ Phone #: (_____) _____

General Physician: _____ How did you hear about our office? _____

If you are under 18 years old, please list parents' names: _____

Who will be responsible for your account? Self Spouse Father Mother Other: _____

Name (First) _____ (Last) _____ SS#: _____ DOB: _____

Mailing Address: _____ City: _____

State: _____ Zip: _____ Home Phone #: (_____) _____ Cell Phone #: (_____) _____

Employer: _____ Work Phone #: (_____) _____

RELEASE OF MEDICAL INFORMATION:

I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits directly to the Hearing & Balance Center, Inc. for services performed. Non-covered services or services are my responsibility.

Signature of Patient: (*Parent or Guardian of minor)* X_____ Date: _____

PAYMENT OF INSURANCE BENEFITS/ FINANCIAL POLICY

We make every effort to keep down the cost of your hearing care. An estimate of the charge for any service you may require will be given to you. If you have any insurance we will be glad to fill out the proper forms. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is NOT a substitution for payment. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

The initial payment is due the day you pick up your hearing aid(s). We will call your insurance as a courtesy, but you must remember that we can only get an estimate of coverage and NOT the exact amount. If your insurance does not cover any part of the services; or if you have no insurance coverage, you are responsible for the billed amount. For your convenience we accept MasterCard and Visa, in addition to Care Credit. We will be happy to discuss these options with you.

Please note, in the event that you fail to make payment when due, this account will be referred to a collection agency. You will be responsible for all collection costs, attorney fees, and court costs.

As the patient/responsible party, I have read, understand, and agree to the terms set forth in the current Financial Policy and accept full financial responsibility for this account.

Signature of Patient: *(Parent or Guardian of minor)* X _____ Date: _____

The Hearing and Balance Center **Today's Date**_____

NOTICE OF PRIVACY POLICY PRACTICES AND POLICIES CONSENT FORM

I give permission to The Hearing and Balance Center to release my protected health information (PHI), verbal and written, contained in my medical record to my health insurance company, related healthcare providers, The Hearing and Balace Centers' business associates when required to complete my care, and to the individuals listed below:

_____ _____

Name of Individual Relationship

_____ _____

Name of Individual Relationship

All other requests for information must be submitted in writing to The Hearing and Balance Center, by the patient or assignees.

In order for The Hearing and Balance Center to mail me pertinent information including but not limited to any upcoming seminars, events, I authorize The Hearing and Balance Center to disclose my name to our marketing partners, for the sole purpose of mailing. All protected health information i.e. name and address will never be sold.

I have been informed of and have available to me, The Hearing and Balance Centers' complete Notice of Privacy Policy pursuant to HIPAA. The Notice provides information about how we may use and disclose medical information that we maintain about you, and we encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area. I understand I am entitled to receive a copy of the Notice of Privacy Policy at any time.

CONSENT FOR TREATMENT/RELEASE OF LIABILITY

I consent to receive audiological services from The Hearing and Balance Center. The consent encompasses audiological procedures including, but not limited to, diagnostic testing, rehabilitative treatment, ear wax removal, and taking earmold impressions. I understand that my audiologist will go over the procedure and any risks of wax removal and/or earmold impressions and by signing below accept those risks and release The Hearing and Balance Center from any liability. I understand that this consent form will be valid and remain in effect as long as I receive audiological care from The Hearing and Balance Center.

I have read all the information on this sheet and give The Hearing and Balance Center permission to treat my concerns.

_____Date:_____

Patient Signature of Parent/Guardian if Patient is a Minor

_____

Print Name