AUDIOLOGY ASSOCIATES
OF SOUTH FLORIDA, INC.

Patient Information:

Name: _____ Male/Female
Last First Middle (Circle One)

Address: _____

Address: _____
City State Zip

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Mothers SS#: _____

Guarantor Name: _____ Relationship to patient: _____

Insurance Name: _____

Pediatrician: _____ _____ _____
Name **Phone** **Fax**

ENT: _____ _____ _____
Name **Phone** **Fax**

CDTC Early Steps: _____ _____ **954-779-2316**
Coordinator Name **Phone** **Fax**

T/Coast Early Steps: _____ _____ **561-881-0972**
Coordinator Name **Phone** **Fax**

.....

I understand and agree that (regardless of my insurance status); I am responsible for the balance of my account. I have read the information on this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify Audiology Associates of South Florida of any changes in my health status or the above information.

Signature: _____ Date: _____

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Policy and Procedures

Our practice participates with most major insurance carriers; therefore we are obligated to follow the policies of your plan regarding authorizations, verifications, co-pays, and deductibles. Co-pays are required prior to your doctor visit, and you will be responsible for any deductibles that your coverage imposes. If you are unable to pay your co-pay at the time of your visit, a service charge of $10.00 will be added to your bill for the services on that day.

When required, patients will not be seen without a referral or an authorization, and it is the patient's responsibility to ensure that their Primary Care Physician or insurance plan has forwarded the appropriate documentation. This is done not only to ensure payment of claims but avoid the patient being responsible for all medical bills that might arise out of a problem discovered at an unauthorized visit.

By signing this form, the patient authorizes payment of Medicare benefits to be made on their behalf to Audiology Associates of South Florida, for services provided to the patient by Audiology Associates medical staff. The patient authorizes any holder of medical information about them to be released to the Center of Medicare and Medicaid Services and its agents, along with any information needed to determine these benefits or the benefits payable to related services.

Financial Agreement: The patient understands that they are financially responsible for charges not covered by their insurance policy, including any co-insurance, co-payments, deductibles, or any other charges that the insurance carrier declines to pay.

Insurance companies often require a referral or authorization for services performed at in our office. It is the responsibility of the patient and/or guarantor to ensure an authorization or referral is on file at the time of your appointment.

If the patient fails to obtain a referral or necessary authorization for the appointment we will have no option than to reschedule the appointment for a later date. If by any reason the patient has been seen by the doctor without a referral or authorization it will be the responsibility of the patient for the services performed. It is the patient's responsibility, as the policyholder of the insurance, to fully understand the rules and regulations of their insurance policy.

Please be advised that not all of the services we provide will be billed to your insurance carrier. Some of our testing is specialized and is not covered by insurance. Please note you are responsible to pay for these tests at the time the service is rendered.

Also, please be aware of what is covered and what is not covered under your particular insurance plan. **WE DO NOT PRE-VERIFY FOR ALL OF OUR PATIENTS AND THE SERVICES WE PROVIDE.** If there is a service that is not covered by your insurance company, you will become the liable party should your insurance company not pay.

Signature: _____ Date: _____
Signature of Patient/Parent/Guardian

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Due to the ever growing and changing insurance markets, we are unable to verify if we are participating with your insurance company. It will be left up to you to pre-verify that we are participating with your insurance company or their network. If we do not participate with your insurance plan, you will be responsible to pay for the service being rendered.

The patient also understands that, if for any reason, their insurance company does not pay within 60 days they will be fully responsible for payment. Any returned checks will incur a $30.00 minimum returned check fee. In the event the account becomes delinquent and is turned over to a collection agency, the patient is responsible for any collection, court, or attorney fees.

_____Initial

Canceling appointments: Audiology Associates of South Florida requires a 24 hour notice, prior to the appointment, to cancel a scheduled appointment. Failure to provide such notice will result in the patient being charged a $25.00 cancelation fee. Failure to show up to your appointment will also result in a $25.00 cancelation fee.

_____Initial

Medical Record Copies: Please note the following in accordance with Florida Statues: For copies of chart pages, a minimum of ten working days and not more than thirty is required to process your request. These copies will be billed to you at $1.00 per page for the first 25 pages and .25 cents per page after that, payable prior to release of your copies. Reproduction of Photographic materials will require additional time over and above the ten days. Payment must be received prior to release. Any retrieval of records in the offsite storage will be charged the retrieval fee.

_____Initial

Consent for Testing:

The undersigned hereby consents to any testing procedures or services rendered to the patient by Audiology Associates of South Florida. I also acknowledge that no guarantee or warranty has been made by Audiology Associates of South Florida as to the results of any testing which may be performed.

Assignment of Insurance Benefits:

I hereby authorize payment directly to Audiology Associates of South Florida and/or Dr. Roberta Randel of the medical benefits under the insurance coverage identified on the information sheet and any others which may be payable to me for all services rendered. I understand I am financially responsible for all the charges not paid under this assignment. I authorize the use of this signature on all my insurance submissions whether manual or electronic. If collection becomes necessary, I agree to pay all costs including attorney's fees.

Signature: _____ Date: _____

Signature of Patient/Parent/Guardian

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Notice of Health Information Practice

I have been provided the opportunity to read, or it has been read to me, the Notice of Health Information Practices for Audiology Associates of South Florida.

I understand that Audiology Associates of South Florida is committed to treating and using protected health information about me responsibly.

I understand my rights as it relates to my records at Audiology Associates of South Florida.

I understand that my health record is the legal property of Audiology Associates of South Florida, but the information belongs to me. I may have access to inspect, amend or obtain a copy of my health information. Costs will incur for copies of my records, and appointments must be made with the Privacy Officer to inspect, access or amend my health information.

I understand that Audiology Associates of South Florida is required to maintain the privacy of my health information. Audiology Associates of South Florida will require my authorization to release my health information to outside sources with the exception of disclosures for purposes of treatment, payment, and healthcare operations. These may include: access to my health information by Audiology Associates of South Florida staff and doctors; billing to myself or a third party payer; in addition, business associates of Audiology Associates of South Florida, may from time to time, have access to my health information, but I am assured that proper business associates agreements are in place, insuring the protection of my health information, upon the doctor's best judgment, we may disclose to a family member, relative or close personal friend or any other persons you identify, health information relevant to that person's involvement in my care; may be used for research data; funeral directors, organ procurement; marketing, FAD; public health or legal authorities; and/or law enforcement purposes.

Audiology Associates of South Florida may call me with appointment reminders, cancellations, and may leave a voice message at my home, cell phone, or place of employment.

I have read and understand the Health Information Practices of Audiology Associates of South Florida.

Emergency Contact: _____ Relationship: _____

Phone Number of Contact: _____

HIPAA Contact List

Audiology Associates of South Florida and staff have my permission to speak to the following family members/friends in reference to my medical care:

_____Relationship_____

_____Relationship_____

_____Relationship_____

Signature: _____ Date: _____

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Children's Hearing History

When did your child's hearing problem begin? _____

Do you think your child's hearing has changed? _____ If so, when? _____

Was there an illness/accident preceding the hearing loss? _____ Describe: _____

_____

Is there a family history of hearing loss? _____

Date and place of last hearing test: _____

Any other related testing? _____

For example: Speech, Neurological, Psychological, Occupational, or Physical Therapy

Has your child ever been diagnosed with a genetic disorder? _____

Please list any significant illnesses: _____

Has your child ever seen an ear/nose/throat specialist? _____ If so, when and where: _____

_____

Date and type of any head trauma: _____

History of ear infections: _____ Date of last infection? _____ any drainage? Right/Left _____

History of allergies: _____ Asthma: _____ GE Reflux: _____ Snoring: _____

Birth History

Length of Pregnancy: _____ Weeks Type of Delivery: _____

Birth Weight: _____ Complications during Birth: _____

Name of Hospital Baby was born in: _____

Was the baby in Neonatal Intensive Care (NICU)? _____

Does your child respond to:						
	Doorbell Ring	YES	NO	Soft Voice	YES	NO
	Telephone	YES	NO	Loud Noise	YES	NO
	Radio/TV/Movies/Music	YES	NO			

If your child wears a hearing aid:

Type: _____ Ear(s) Fitted: _____

Brand: _____ When Purchased: _____

Name of school your child attends: _____

Do the teachers have concerns regarding behavior or school work? _____

_____

If you child receives special services at school please describe: _____

_____

AUDIOLOGY ASSOCIATES
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AUTHORIZATION TO RELEASE MEDICAL RECORDS

(This authorization complies with HIPAA)

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)
Address (Street Address, City, State, Zip Code)	
Phone Number	E-mail

Printed Name of Guardian or Legal Representative (first, middle, last name)	
Address (Street Address, City, State, Zip Code)	
Phone Number	E-mail

I hereby authorize that any health care professional may receive the following health information that relates to service performed by Audiology Associates of South Florida may be released:

- Entire Medical Record including patient histories, office notes, test results, and consults.
- Patient Histories
- Office Notes
- Test Results
- Consults

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

This authorization is valid for 24 months following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Signature of Patient or Personal Representative:	Date Signed:	Print Name of person signing this form: Relation to the patient:

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COVID-19 PATIENT ATTESTATION FORM

We are committed to protecting the safety and well-being of the patients we serve, their families as well as our employees. We will follow the instructions and guidelines provided by local, state and the federal Department of Health and do our best to continue providing care.

If a patient or a household member of the patient contracts COVID-19 or present with symptoms or other risk factors, that patient will not receive services for no less than 14 days. Affected patients will be required to present a doctor's note to our center that permits them to return to our center and/or must provide information to our center that they are symptom free for at least 14 consecutive days.

In addition, patients receiving services attest the following:

That they or a household member has not recently traveled during the past 14 days

That they or a household member has not come in close contact (within 6 feet) with someone who has A confirmed COVID-19 diagnoses in the past 14 days

Within the past 14 days, they have not had a fever (greater than 100.4F or 38.0C)

Within the past 14 days, they are not experiencing any symptoms of a respiratory illness, such as cough, shortness of breath, difficulty breathing or sore throat

By signing this attestation form, patient or guardian confirms that they have read and reviewed the above which is required on an ongoing basis as part of their continued service of care with Audiology Associates of South Florida. Should any of the above change, patient or guardian will immediately notify our center.

_____ _____

Patient or Guardian Signature Date

_____

Patient's Name

5411 N. University Dr., Ste 102 – Coral Springs, FL 33067
Phone: 954-752-1559 **Fax: 954-825-2029**