

117 Harmony Crossing
Suite 8
Eatonton, GA 31024
706-453-2119

**Advanced Audiology & Hearing Care
Patient Registration**

Patient Name: Last _____ First _____ MI _____

Street Address: _____ City: _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____
(please circle the phone # you prefer to be contacted on)

Email _____ May we contact you via email? Yes ___ No ___

Date of Birth: _____ Age: _____ Male ___ Female ___ Marital Status S ___ M ___ D ___ W ___

Emergency Contact: Name: _____ Phone: _____ Relationship: _____

If Policy Holder is NOT the patient, Please complete the following:

Policy Holder Name: Last _____ First _____ MI _____ Date of Birth: _____

Relationship: Spouse ___ Child ___ Other ___ Employer of Policy Holder: _____

Circle all that apply

Have you had any COVID-19 symptoms: Yes No

Fever Chills Cough Shortness of breath Fatigue Body aches Headache Loss of taste Loss
of smell Sore throat Congestion Runny nose Nausea Vomiting Diarrhea

Have you tested positive for COVID-19 : Yes / No Date _____ Retest date _____

Have you been exposed to someone with COVID-19: Yes / No Date _____

Do you have a Latex allergy: Yes / No Tobacco User: Yes / No

- Primary Care Physician _____ Phone# _____
- Referring Physician _____ Phone# _____
- Ear Nose & Throat Physician _____ Phone# _____

May we send a copy of your test results to your physician? Yes _____ No _____

How did you hear about us?

____ From another patient Name: _____

____ From your physician Name: _____

____ Newspaper Ad ___ Direct Mail ___ TV Ad ___ Website ___ Magazine Ad

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Advanced Audiology & Hearing Care Hearing History

Name: _____ Date: _____
(first) (m.i.) (last)

1. What is your main reason for coming in? _____

2. History of medical problems you're your ears: _____

Ear surgery _____	Perforated eardrum _____
Ear infection _____	Earwax build up _____
Ringing/buzzing _____	Dizziness _____
Noise exposure _____	Family hx _____

3. Other health conditions: _____

4. Current medications: _____

5. Hearing aid experience? None
 I tried devices in past, but did not keep
 I have hearing devices, but don't use them
 I currently wear hearing devices

6. Check the situations in which you are having difficulty hearing:

<input type="checkbox"/> One-on-one in quiet room	<input type="checkbox"/> Television	<input type="checkbox"/> Radio
<input type="checkbox"/> Group conversation	<input type="checkbox"/> Cell Phone	<input type="checkbox"/> Music
<input type="checkbox"/> Telephone (at home)	<input type="checkbox"/> Church	<input type="checkbox"/> Outdoors
<input type="checkbox"/> Places with background noise	<input type="checkbox"/> Car	<input type="checkbox"/> Meetings
<input type="checkbox"/> At work	<input type="checkbox"/> Restaurants	<input type="checkbox"/> Sales Clerk
<input type="checkbox"/> Other(s) _____		

7. Rate the following items from 1 to 4 in terms of importance to you when considering hearing devices:

1= most important 2= important 3= neutral 4= not important

<input type="checkbox"/> Sound quality & clarity	<input type="checkbox"/> Ease of Use	<input type="checkbox"/> Cost
<input type="checkbox"/> Reliability	<input type="checkbox"/> Latest Technology	<input type="checkbox"/> Cosmetics

8. On a scale from 0 to 10, how motivated are you about improving your hearing?

0	1	2	3	4	5	6	7	8	9	10
not motivated				somewhat motivated						very motivated

Advanced Audiology and Hearing Care, LLC

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www.hearlakeoconee.com

Authorization for Assessment: I hereby authorize the Audiologist and/or assistants to administer all diagnostic measures and/or services that may be deemed necessary. I understand no guarantee or assurance can be made as a result of this service.

Authorization for Release of Information: I hereby authorize Advanced Audiology and Hearing Care, LLC to release diagnostic and procedural information for the completion of my insurance claim form. I authorize the release of clinical information to referring physicians and facilities for the purpose of continued audio logical and/or hearing care.

HIPAA REQUIREMENTS

Please provide names of persons that we may release your medical information to:

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____

May non-medical information be left on your answering machine? Yes ___ No ___

Authorization of Insurance Benefits: I authorize payment directly to Advanced Audiology and Hearing Care, LLC the benefits otherwise payable to me but not to exceed the regular charges for these services. I understand I am financially responsible to Advanced Audiology and Hearing Care, LLC for charges not covered by my insurance.

Medicare Consent: I request the payment of authorized Medicare benefits be made on my behalf to Advanced Audiology and Hearing Care, LLC for any diagnostic measures and/or services deemed necessary. I authorize my holder of medical information to release any information needed to determine these benefits or the benefits payable for related services for the Health Care Financing Administration and its agents. I permit a copy of this authorization to be used in place of the original.

Billing and Credit Policy: My account will be considered due at the time of treatment. As a courtesy to me, the Business Office will process my insurance if proper information is provided. It is understood that all insurance co-pays be paid at the time of appointment. I will be billed on the current balance of my account regardless of the insurance claim status.

Patient/Responsible Party Staff Signature Date

Advanced Audiology & Hearing Care Financial Agreement

Payment is expected at the time of service unless other arrangements have been made. We accept cash, checks, MasterCard, Visa and Care Credit.

- We will submit charges directly to your insurance carrier as a courtesy. Submitting the charges is no guarantee that they will be paid.
- Insurance policies may or may not pay for the services you receive at our office. Coverage varies with each insurance carrier. The amount your insurance company pays for the services you receive is between you and your insurance carrier.
- You are responsible for paying all co-payments at the time of service.
- You are responsible for paying all charges including those that go towards your deductible, co-insurance, services, hearing devices when applicable, and all other related items not covered by insurance. Accounts not paid within 90 days of the date of service may go to a collection agency, unless other payment options have been made in writing with Dr. Kimberly Hoffman.
- All hearing instruments and/or assistive listening devices that have been ordered specifically for you and not picked up will be subject to a restocking fee including shipping and handling when returned to the manufacturer.
- Custom earmolds and/or impression costs are non-refundable and must be paid in full at the time of the earmold impression appointment.
- Payments on extensions of warranties are due at that time. A credit card payment can be made over the phone; however, no extensions will be made without payment.

Patient Signature

Date

Advanced Audiology & Hearing Care

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____ have received a copy of
ADVANCED AUDIOLOGY & HEARING CARE’S Notice of Privacy Practices.

Signature of Patient

Date