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:_____

Have you tested positive for COVID-19 : Yes / No Date_____ Retest date_____

Have you had a COVID-19 Vaccine ? Yes / No Date_____ 2nd 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_____

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:_____

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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:

____One-on-one in quiet room	____Television	____Radio
____Group conversation	____Cell Phone	____Music
____Telephone (at home)	____Church	____Outdoors
____Places with background noise	____Car	____Meetings
____At work	____Restaurants	____Sales Clerk

____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

____ Sound quality & clarity	____ Ease of Use	____ Cost
____ Reliability	____ Latest Technology	____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

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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