Atlantic
Hearing, Balance, & Tinnitus Center
hear well. live well.

Demographics:

Name: _____ Today's Date: _____
Address: _____
Birthdate: _____ Email: _____ Age: _____
Social Security Number: _____ Employer: _____
Marital Status: ___Single ___Married ___Widowed ___Divorced ___Other
___Mr. ___Mrs. ___Ms. ___Miss ___Dr.

If patient is under the age of 18, please provide:
Name of Parent or Guardian _____ Phone _____

Insurance Information:
Name of Person Insured, if other than you: _____
Your relationship to the Person Insured (wife/husband/sister/friend, etc.) _____ DOB: _____
Name of Insurance Company:
First: _____Second:_____
Third: _____

Referring/Primary care Physician:
Name _____Phone _____
Address_____
How did you hear about us? _____

Assignment of Insurance Benefits/Release of Information: Please initial
____ Insurance coverage is an agreement between you and your insurance carrier. I hereby assign all insurance benefits to which I am entitled, including Medicare, private insurance, and any other health plans to Atlantic Hearing & Balance. The assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance within 30 days, based on my individual insurance benefits/contracts. I hereby authorize said assignee to release all information that is necessary to secure payment.

Permission for Treatment: Please initial
____ I hereby voluntarily consent to audiological care and audiological diagnosis by Atlantic Hearing & Balance, deemed advisable and necessary in the diagnosis and treatment of my hearing condition. I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

Receipt of Notice of Privacy Policy: Please initial
____ I have received a copy of Atlantic Hearing, Balance, & Tinnitus Center's Privacy Practices and understand its contents.

Disclosure of Patient Authorization Record
I authorize that my personal information, hearing healthcare treatment, and financial information may be assessed by and disclosed to the individuals listed (I.e. spouse, family member, caregiver, friend, etc.)

Name	Relation	Telephone #
_____	_____	_____
_____	_____	_____
_____	_____	_____

HEARING HISTORY:

Have you ever had a hearing evaluation before? ___ Yes ___ No
If you suspect a hearing loss, do you feel the onset was: ___ Gradual ___ Sudden __ Fluctuating
Have you been around loud sounds regularly? ___ Yes ___ No

Do you have trouble hearing any of the following?

____ Doorbell ____ Telephone Ring ____ Alarm Clock ____ Sirens
____ Baby Cry ____ Fire/Smoke Detector ____ Bird Singing ____ Car Blinker

Have you ever worn a hearing aid? ___Yes ___ No
Do you use a hearing aid now? ___ Yes ___ No

MEDICAL HISTORY:

Have you had earaches or drainage from your ears in the past 90 days? ___ Yes ___ No
Have you ever had medical/surgical treatment for your eats? ___ Yes ___ No
Do you ever experience balance issues, dizziness, lightheadedness, or falls? ___ Yes ___ No
Have you ever had a head injury? ___ Yes ___ No
Do you experience tinnitus regularly (i.e. ringing, buzzing, humming, roaring)? ___ Yes ___ No
Do you have a family history of hearing loss? ___ Yes ___ No

Please mark all that apply:

___Arthritis	___Pacemaker	___Measles	___Allergies
___Diabetes Type 1	___Diabetes Type 2	___Multiple Sclerosis	___Stroke/TIA
___Bell's Palsy	___Hepatitis	___Mumps	___Tuberculosis
___Cancer	___High/Low Blood Pressure	___High Fevers	___Forgetfulness
___Vision Issues	___Concussion/Skull Fracture	___Scarlet Fever	___Parkinson's
___Dementia/Alzheimer's	___HIV/AIDs	___Seizures	___Depression

___Other, please explain: _____

Are you allergic to latex, acrylic, silicone, etc.? ___ Yes ___No
If yes, please list which one: _____

Please provide a copy of your medication list or list them all here: _____
_____

Please list any serious illnesses/surgeries: _____
_____

Is there any other important information related to your hearing that the doctor should know?
_____
_____
_____

Confidential Communication

I authorize communication by Atlantic Hearing, Balance, & Tinnitus Center concerning scheduled appointments, treatment, practice information, newsletter, etc. Through the following methods:

Please select all that apply: ____ Phone ____ Text ____ Email ____ Work
Home: _____ Authorize Message ___ Yes ___ No
Cell: _____ Authorize Message ___ Yes ___ No
Work:_____ Authorize Message ___ Yes ___ No

Hearing Inventory ***FOR COMPANION***

Name: _____ Date: _____ HI Score: _____
Patient: _____ Relationship to Patient: _____

At Atlantic Hearing & Balance, it is our mission to find the best personal solution for each person's communication needs. We will only be successful in reaching this goal if we take the time to compile the following information from those closest to you. Communication is a two-way street!

	Yes	Sometimes	No
Have you observed a situation where a hearing problem caused him/her to feel embarrassed when meeting new people?			
Do you feel a hearing problem causes him/her to feel frustrated when talking to members of his/her family?			
Have you noticed that he/she has difficulty hearing when someone speaks in a whisper?			
Do you believe he/she is burdened by a hearing problem?			
Are you concerned that a hearing problem causes he/she difficulty when visiting friends, relatives, or neighbors?			
Do you think that a hearing problem causes he/she to attend large group situations less often than they would like?			
Have you noticed that a hearing problem causes he/she to have arguments with family members?			
Have you noticed that a hearing problem causes he/she difficulty when listening to TV or radio?			
Are you concerned that any difficulty with his/her hearing limits or hampers their personal or social life?			
Have you observed that a hearing problem cause him/her difficulty when in a restaurant with relatives or friends?			

Is there any other important information related to the patient's hearing or communication that the doctor should know?

_____
_____
_____

Hearing Handicap Inventory (HHIE-S)

Instructions: Please check “yes”, “no”, or “sometimes” in response to each of the following items. Do not skip a question if you avoid a situation because of a hearing problem. If you use a hearing aid, please answer the way you hear *without* the aid.

	Item	Yes	Sometimes	No
E	Does the hearing problem cause you to feel embarrassed when meeting new people?			
E	Does a hearing problem cause you to feel frustrated when talking to members of your family?			
S	Do you have difficulty hearing when someone speaks in a whisper?			
E	Do you feel handicapped by a hearing problem?			
S	Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?			
S	Does a hearing problem cause you to attend religious services less often than you would like?			
E	Does a hearing problem cause you to have arguments with a family member?			
S	Does a hearing problem cause you difficulty when listening to TV or radio?			
E	Do you feel that any difficulty with your hearing limits or hampers your personal or social life?			
S	Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?			

OFFICE & FINANCIAL POLICY

Welcome to our Office

Please read this policy carefully and feel free to ask questions regarding any part of the form. Our goal is to provide you excellent hearing care in a comfortable, personal, and cost-effect manner. We hope that you will recognize that our financial policies have been developed to maintain this health care service for our patients and for the community, which means lower fees for you. You can help by paying for your care in a timely manner.

Payment at the time of service is expected.

Payment for services is due in full at the time of service. Payments to Atlantic Hearing, Balance, & Tinnitus Center may be made by cash, check, Visa, MasterCard, or approved financing companies.

In order to bill your insurance company for your hearing care, it is extremely important that we obtain complete and accurate information about your primary and supplemental insurance coverage, including phone numbers, addresses, and a copy of your cards. Even though we bill your insurance company for you, we will still collect any office copayments from you at the time of service.

Verification of Benefits

We may assist you, at our discretion, in verifying your insurance coverage in an effort to verify exactly what audiology coverage is available within your policy. This can only be done on the day of your appointment if time permits. **You as the policy holder are primarily responsible to verify benefits.** We cannot guarantee payment of benefits and subsequently you may be responsible for any coinsurance, deductibles, or fees for non-covered services that may result. Insurance coverage is an agreement between you and your insurance carrier.

Referrals

If your insurance company requires a referral and/or preauthorization/precertification you ae responsible for obtaining it. We most likely will not be able to obtain a referral on the date of service. (This will be at our discretion if time permits). An option at this point will be to reschedule the appointment or to pay at the time of service. We suggest you call your primary care doctor at least 24 hours in advance to confirm that your referral has been generated and faxed. **The most reliable method is to obtain it yourself.**

Medicare

We accept assignment from Medicare so all payments from Medicare will be made directly to the doctor. We bill Medicare and your supplemental insurance directly. We are required by Federal Law to collect the amount Medicare approves, not just the 20% they do not pay.

No Show and Cancellation Appointments/Late Arrivals

We will reach out to you at least the day before your appointment to confirm your attendance. If we do not reach you, we will leave a message via voicemail or email (if able). Please give at least 24-hours' notice if unable to keep an appointment. We reserve the right to charge a $25 fee for missed appointments or appointment cancelled without a 24-hour notice. We understand late arrivals happen. Unfortunately, we have patients scheduled throughout the day and may not be able to see you if you arrive more than 15 minutes after you scheduled appointment time. We will try to accommodate you if time allows, otherwise, we will need to reschedule.

Returned Checks

There is a fee (currently $25) for any checks returned by the bank.

Monthly Statement

If your account has a balance we will send you a monthly statement. It will show the balance and any new charges to the account, which will be the patient's responsibility.

Payments

Unless other arrangements are approved by us in writing, the balance on your account is due and paid within 30 days after the statement is issued. If the account is not paid within the 30 day time period it will be considered **past due** and be subject to additional past due charges and be subject to a 1.5% interest fee per month.

Past Due Accounts

If your account is past due, in addition to past due charges we will take the necessary steps to collect this debt by means of collection services. In the event of legal action, you will be responsible for payment of any additional charges equal to the cost of collections, including agency fees, attorney fees, and court costs incurred, as permitted by law governing this transaction.

Effective Date

Once you have signed this document, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect. _____please initial

Financial Agreement: please initial

_____ I agree to pay promptly all fees and charges for treatments provided to me, the patient.

_____ I understand that I am financially responsible for all charges within 30 days of my appointment date, whether or not they are covered by my insurance.

_____ I authorize Atlantic Hearing, Balance, & Tinnitus Center to release to my insurance carrier any medical information needed to obtain payment for services.

_____ I understand that if I disagree with any charges, I will contact this office in writing within 30 days of billing date.

We will work with you to ensure your hearing care is the finest available and it does not become a financial burden.

Signature: _____Date: _____