Audiological Services (Main Office)
601 Ellis AVE, Lufkin, TX 75904
(936) 632-2252

All About Hearing
2703 W Cuthbert AVE, Midland, TX 79701
(432) 689-2220

Central Texas Hearing Center
1320 Wonder World DR, #107, San Marcos, TX 78666
(512) 667-7921

Central Texas Hearing Center
1927 Lohman's Crossing Rd., Ste 203, Lakeway, TX 78734
(512) 640-2999

INITIAL REGISTRATION

PATIENT INFORMATION

LEGAL NAME - FIRST:_____MI:_____ LAST:_____
NICKNAME: _____ DATE OF BIRTH:_____ SS#_____
MAILING ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____
HOME PHONE: _____ WORK PHONE: _____ CELL PHONE:_____
EMAIL ADDRESS:_____
PARENT'S NAME (IF MINOR):(MOTHER)_____ (FATHER)_____
MARITAL STATUS: ☐Single / ☐Married / ☐Other SPOUSE: _____DOB:_____
PRIMARY CARE PHYSICIAN:_____

Is this patient in a **SKILLED NURSING FACILITY** (☐YES / ☐NO) Facility Name:_____
Is this patient in an **ASSISTED LIVING FACILITY** (☐YES / ☐NO) Facility Name:_____
Is this patient on **HOSPICE** (☐ YES / ☐ NO) Facility Name:

INSURANCE INFORMATION

PRIMARY INS. CO:_____ INSURANCE PLAN TYPE:_____
ID #: _____GRP/POLICY#:_____
POLICY HOLDER'S NAME: _____GENDER: ☐M / ☐F DOB:_____
POLICY HOLDER'S EMPLOYER: _____
PATIENT RELATIONSHIP TO POLICY HOLDER: ☐Self ☐Spouse ☐Child ☐Other

SECONDARY INS. CO:_____INSURANCE PLAN TYPE:_____
ID #: _____GRP/POLICY#:_____
POLICY HOLDER'S NAME: _____GENDER: ☐M / ☐F DOB:_____
POLICY HOLDER'S EMPLOYER: _____
PATIENT RELATIONSHIP TO POLICY HOLDER: ☐Self ☐Spouse ☐Child ☐Other

REFERRAL INFORMATION

☐ Physician_____
☐ Insurance_____
☐ Employer _____
☐ Friend _____
☐ Event_____
☐ Other_____

☐ Phone Book
☐ Radio
☐TV ☐ Newspaper
☐ Direct mail
☐ Outdoor Sign

ONLINE SOURCES

☐ Yelp ☐Google Ad
☐ Facebook ☐ Google+
☐ LinkedIn ☐ Google Maps
☐ Website

OFFICE POLICIES & CONSENT

No Show/Cancellation Policy: When we schedule an appointment, we set aside time for you to receive the highest quality care. If you need to cancel and appointment, please contact our office no later than the day before your scheduled appointment.

If you fail to present for a scheduled appointment, without contacting the office at least 24 hours prior to the appointment, you will be considered a "No Show" and will be charged a fee of $50. This fee is charged to you, not your insurance company, and it is due at the time of your next appointment.

Payment: FULL PAYMENT IS DUE AT TIME SERVICES ARE RENDERED, unless other arrangements have been made. There will be a $25.00 fee for returned checks. Cash, checks, Visa, Master Card, American Express, Discover and Care Credit are accepted options.

Insurance Responsibility Statement: Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on various contracts. It is my responsibility to pay the deductible, co-insurance and other balances not paid by my insurance. I understand that _____ may provide an estimate of my insurance coverage and files insurance forms as a courtesy. _____ will assist me in receiving reimbursement as much as possible, but I am responsible for my account.

Assignment of Insurance Benefits: I hereby authorize and instruct my insurance carrier(s) to make payment directly to _____ for the expense of benefits otherwise payable to me. I understand that I am financially responsible to _____ for charges incurred. I further assign all payment due me for services rendered under said policies. This assignment will remain in effect until revoked by me.

Acknowledgement of Receipt of Privacy Notice / HIPAA: The Notice provides information about how my medical information may be used and disclosed. I understand that a copy of the current Notice is in the reception area, and that I may take a copy with me at any time. Any revised Notice of Privacy Practices will be made available.

Authorization to Release Information: I authorize _____ to release the records relating to my identity and/or other health care information by telephone, in writing or pictorial, to my health care and/or service provider(s). I authorize the release of the same information to insurance carrier(s) and fiscal intermediaries or their representatives for reimbursement or utilization review. Also, I authorize _____ to share my medical information with:

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

****I do not authorization the release of my health and/or financial information to ANY family members or friends**** _____
Initials

☐ I authorize the release of my hearing health records to my primary care physician (listed on registration form)

☐ I authorize the release of my child's hearing health records to his/her school

Name of School: _____ Fax:_____

Address:_____

By signing below, I represent that all information provided by me is true and that I have read and understand the above paragraphs regarding financial obligation, insurance responsibility, assignment of insurance benefits, acknowledgement of Notice of Privacy Practices and authorization to release information.

_____ _____

Signature of Patient / Responsible Individual Date *Signature of Witness Date*

Patient Name: _____