PEDIATRIC REGISTRATION FORM
(Please Print)

Today's date:	Email:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Accompanied by:

Is this their legal name? ❑ Yes ❑ No	If not, what is their legal name?	(Nickname):	Birth date: / /	Age:	Sex: ❑ Male ❑ Female ❑ Other

Street address:	Cell phone no.:	Home phone no.: ( )

Apartment/Unit Number:	City:	State:	ZIP Code:

Parent/Guardians Names:	Pediatrician:	Pediatrician's phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Speech Clinic ❑ Other

Other family members seen here:

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Required by the Health Insurance Portability and Accountability Act ---- 45 CFR Parts 160 and 164)

1. I hereby authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

2. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

3. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

4. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the clinic. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

PATIENT HIPAA CONSENT FORM / NOTICES OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: _____

With my consent and signature, Autumn Oak Hearing & Balance may use and disclose protected health information about me to:

1. Carry out treatment, payment, and healthcare operations (services).
2. Call my home or other designated locations and leave a message on voice mail in reference to any items (i.e. appointment reminders, insurance items, references to clinical care of laboratory results, etc.) that will assist in the practice of medical care for me.
3. Mail to my home or other designated address any item (i.e. appointment reminder cards, patient financial statements, etc.) that will assist in practice of medical care from me. Such correspondence is to be marked personal and confidential.
4. Send or transmit email to any location provided by me for all above similar items and purposes.
5. To use and/or disclose protected health information about me to/with third parties involved in my care. Such parties may include, but are not limited to, insurance companies, hospitals, specialty physicians, and laboratory personnel. I may specifically describe the type of information (i.e. dates of services, level of detail, origin of information, etc.) subject to disclosure and may revoke this permission at a time and date chosen by me. By providing a written statement to the privacy office Autumn Oak Hearing & Balance, I may revoke this permission; however, Autumn Oak Hearing & Balance may decline to provide further treatment to me. Autumn Oak Hearing & Balance may also decline further treatment to me should my restrictions on the type of third-party information, in the center's opinion, impede medical care of me.

I have the right to review the Notice of Privacy Practice Manual of Autumn Oak Hearing & Balance. Autumn Oak Hearing & Balance may revise its manual and procedures at any time deemed necessary, and I may request from time to time, in writing, a copy of such changes, should these changes directly relate to my care.

I have the right to request that Autumn Oak Hearing & Balance restrict how it uses or discloses my health information. However, as state previously, Autumn Oak Hearing & Balance is not required to agree to my restrictions. If Autumn Oak Hearing & Balance accepts my restrictions, Autumn Oak Hearing & Balance is then bound by the restriction in the agreement, setting forth the restricted information until providing me, in writing, a cessation of such agreement.

I may revoke this entire consent, in writing, at any time. If I do not sign this consent, or revoke this consent, Autumn Oak Hearing & Balance, in their sole discretion, may decline further treatment for me.

The Federal HIPPA (Privacy Act) of 2001 was created to protect my health information. I understand this must be accomplished within the provisions and rules set up by Autumn Oak Hearing & Balance to fulfill federal law. I may request to review the manual which spells out these provisions. Autumn Oak Hearing & Balance will comply with this law to preserve privacy. If compliance with this law impedes the medical care of the patient, Autumn Oak Hearing & Balance may decline to provide further care. Autumn Oak Hearing & Balance will strive to provide information so that I may make an informed decision concerning the privacy of my medical information.

_____ _____

Patient/Guardian Signature Date

PEDIATRIC PATIENT MEDICAL & HEARING HISOTRY

(Please Print)

Patient's Name: _____ Date: _____

Why have you decided to have this child's hearing tested at this time?

- ☐ I feel their hearing is poor and may need hearing aids
- ☐ Physician Recommended it
- ☐ Failed Screening or speech delay
- ☐ Other reason: _____

Is there any familial history of any of the following?

☐ High Blood Pressure	☐ Heart Disease	☐ Hearing Loss
☐ Cancer	☐ Diabetes	☐ Arthritis
☐ Kidney Disease	☐ Meningitis	☐ Tuberculosis
☐ HIV/AIDS	☐ Head Trauma	☐ Chronic Ear Infections

Have they had any ear surgeries? ☐ Yes ☐ No

List any ear surgeries and date: _____

Have they ever had their hearing tested before? ☐ Yes ☐ No

Estimated Date: _____

Does the child speak yet? ☐ Yes ☐ No

First spoken word at what age: _____

Estimated number of spoken words to date: _____

Have they had any major or minor head injuries? ☐ Yes ☐ No

Any drainage or blood from either ear in the last 90 days? ☐ Yes ☐ No

Any pain or discomfort in the ear? Are they tugging at their ears? ☐ Yes ☐ No

Do others have difficulty understanding the child when they talk? ☐ Yes ☐ No

Does the child have any developmental delays besides speech? ☐ Yes ☐ No

Have they been treated for ear infections by a physician? ☐ Yes ☐ No

Have they had their vision tested? ☐ Yes ☐ No

Do they wear glasses/contacts? ☐ Yes ☐ No

Does the child have any physical disabilities? ☐ Yes ☐ No

Please list them: _____

Does the child have any mental or developmental disabilities? ☐ Yes ☐ No

Please list them: _____

Do they have any allergies? ☐ Yes ☐ No

If so, what are they allergic to?

_____

Please list below all illnesses, injuries and operations (age and complications):

_____

_____

_____

_____

OUR OFFICE POLICIES

(Please Print)

Patient's Name: _____ Date: _____

Thank you for choosing us as your provider. At Autumn Oak Hearing & Balance, we recommend testing that is based off best practices and not what your insurance policy may or may not cover. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial and office policies, which we require you to read and sign prior to any treatment.

Insurance Benefits

You will be given an **ESTIMATED** amount due before services are rendered. Every insurance plan accepted in our office has different percentages, deductibles, maximums, services covered, and varying fees that the plans will allow. We will do our very best to make as close a calculation as possible of what your insurance will cover, HOWEVER, as we cannot guarantee the calculations or payments from any insurance plans.

We may accept assignment of benefits as a service to you. This means we will file a claim with the insurance company for their estimated portion of coverage. However, we are unable to bill your insurance unless you provide us with your current insurance information. The balance is your responsibility whether your insurance pays or not. Any variations or non-covered services are the patient's responsibility if services are rendered at the date of service.

If we do accept the assignment of benefits from your insurance company, we do require that your account is paid in full within 60 days if your insurance has not paid their portion.

Referrals

If a referral is required by your insurance carrier it is your responsibility to obtain the referral prior to your appointment. If no referral exists on file or your referral has not been received, your appointment should be cancelled, or you are responsible for 100% of the cost of services rendered.

Financial Policies

- Full payment is due at time of service.
- There is a $45 service charge for all returned checks. If a check is returned, you will be notified as soon as possible.
- We allow 5 business days for you to bring in payment via cash, credit card or money order.
- If your account goes over 90 days past due, it will be turned over to our collection agency.

Late or Missed Appointments

For our providers to see patients in a timely manner please arrive promptly for your appointment. If you are running late, we ask that you call to inform us as soon as you know you are going to be late. We will let you know if we are able to see you that day or if we need to reschedule your appointment. If you are going to be more than 15 mins late, our office will automatically cancel or reschedule your appointment.

As a courtesy our office will call or text all our patients the day before your appointment for confirmation. **If the patient misses 2 consecutive appointments with our office any future appointments will be cancelled. In addition, a $35 charge will be made for each addition canceled or missed appointment unless a 24-hour notice is given. (Initials: _____)**

Medical Records

Should you need a copy of the medical records, please allow 7-10 business days for completion. Make sure that your Primary Care Provider or any person you may want us to send copies to is written in the **Authorization for Use or Disclosure of Protected Health Information** section of this paperwork.

_____ _____

Patient/Guardian Signature Date