WATERTOWN
AUDIOLOGY
HEARING AID & BALANCE CENTER

CHILD REGISTRATION

Patient Name: _____ Sex: M F
FIRST MI LAST

Date of Birth: _____ / _____ / _____ Age: _____ Social Security Number: _____ - _____ - _____

Address: _____
STREET APT # CITY STATE ZIP

Home Telephone: _____ Cell Phone: _____ Email: _____

Patient's Primary Doctor: _____ Phone: _____

Reason For Visit: _____

PRIMARY INSURANCE	Insurance Name:	ID Number:	Group Number:
	Subscriber:	Subscriber DOB:	Employer:
	Relationship to Patient:	Insurer Phone Number:	

SECONDARY INSURANCE	Insurance Name:	ID Number:	Group Number:
	Subscriber:	Subscriber DOB:	Employer:
	Relationship to Patient:	Insurer Phone Number:	

OTHER INSURANCE	Insurance Name:	ID Number:	Group Number:
	Subscriber:	Subscriber DOB:	Employer:
	Relationship to Patient:	Insurer Phone Number:	

Patient/Parent/Guardian Name (Please Print): _____

Patient/Parent/Guardian Signature: _____ Date: _____

WATERTOWN AUDIOLOGY
HEARING AID & BALANCE CENTER

FINANCIAL AUTHORIZATION

Please give your insurance information to our patient coordinators so we can make a copy for our records

Patient Name: _____ Date of Birth: _____ / _____ / _____
FIRST MI LAST

PLEASE NOTE: The insurance policy holder is not automatically the Billing Guarantor.
The parent/guardian who is present for office visits is the Billing Guarantor

GUARANTOR

Name (First, Middle, Last):	Relationship to Patient:	Date of Birth:
Address:	Home Phone:	Social Security Number:

NOTICE OF FINANCIAL RESPONSIBILITY

BILLING GUARANTOR

I understand that payment of all medical care is due at the time of service. The parent and/or legal guardian who signs this form is responsible for any and all co-payments, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs.

I hereby authorize Watertown Audiology P.C. to release any pertinent information to the health insurance carriers, and I also authorize payment directly to Watertown Audiology P.C. A photocopy of this authorization shall be considered as effective and valid as the original.

NON-COVERED SERVICES

I understand that some services performed by Watertown Audiology P.C. may be considered "non-covered" by your health insurance carriers or Medicaid, therefore I will become fully responsible for payment of these services.

I hereby authorize Watertown Audiology P.C. to release any pertinent information to the health insurance carriers, and I also authorize payment directly to Watertown Audiology P.C. A photocopy of this authorization shall be considered as effective and valid as the original.

DIVORCE/CHILD CUSTODY

Watertown Audiology P.C. will not honor the specific financial arrangements set forth in a Child Custody Agreement, Divorce Settlement Agreement, Divorce Decree from Judgment, or the like (the "Arrangements"). Since Watertown Audiology is not a party to these Arrangements, it is not obligated to the financial terms of these Arrangements.

In cases of child custody, the parent who presents their child (the "Presenting Parent") for care and treatment at Watertown Audiology is responsible for the payment of co-payments, co-insurance and deductibles at the time of service. This policy applies whether there is a joint-custody arrangement of the child and/or joint responsibility for their medical services.

If the child is on the non-custodial or non-presenting parent's health insurance, then Watertown Audiology will still collect the applicable co-payments, co-insurance and deductibles at the time of service from the Presenting Parent. Upon request, Watertown Audiology will provide a duplicate copy of your receipt so that the Presenting Parent or guardian can seek reimbursement where appropriate.

☐ I HAVE READ ALL OF THE ABOVE AND UNDERSTAND/AGREE TO ALL PROVISIONS THEREIN REGARDING FINANCIAL RESPONSIBILITY AND PERMISSION FOR TREATMENT.

Patient/Parent/Guardian Name (Please Print): _____

Patient/Parent/Guardian Signature: _____ Date: _____

WATERTOWN AUDIOLOGY
HEARING AID & BALANCE CENTER

PATIENT AUTHORIZATIONS

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____ (Please Print Your Name), hereby authorize Watertown Audiology P.C. to release protected health information (diagnosis, reports, testing and treatment) for myself or _____ (Child's Name) to the following people:

_____ _____

_____ _____

_____ _____

The information will be handled confidentially in compliance with all applicable state and federal laws

_____ **INITIALS**

NO-SHOW/CANCELLATION POLICY

I understand that it is my responsibility to notify Watertown Audiology P.C. if I am unable to keep my scheduled appointment. Your appointment time is valuable and has been reserved specifically to you. If it is necessary to reschedule your appointment, please provide us with 24 hours notice. An answering machine is available in our office.

Otherwise, a late cancellation or no show fee of $25.00 for a hearing evaluation and $50.00 for a Central Auditory Processing (CAP) Test or a balance and dizziness test will be charged. These charges are not covered or paid for by health insurances. Payment is due at the time of your appointment.

_____ **INITIALS**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I have been given the opportunity to read or obtain a copy of the Notice of Privacy Practices.

_____ **INITIALS**

Patient/Parent/Guardian Name (Please Print): _____

Patient/Parent/Guardian Signature: _____ Date: _____