WATERTOWN AUDIOLOGY
HEARING AID & BALANCE CENTER

PATIENT REGISTRATION

Patient Name: _____ Sex: M ○ F ○
FIRST MI LAST

Date of Birth: _____ / _____ / _____ Age: _____ Marital Status: Single ○ Married ○ Divorced ○ Widow ○

Address: _____
STREET APT # CITY STATE ZIP

Home Telephone: _____ Cell Phone: _____ Occupation: _____

Social Security Number: _____ - _____ - _____ Email Address: _____

Patient's Primary Physician: _____ Phone: _____

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:	

Emergency Contact/Relation: _____ Phone: _____

NOTICE OF FINANCIAL RESPONSIBILITY

I understand that payment of all medical care is due at the time of service. The patient who signs this form is responsible for any and all co-payments, deductibles, co-insurance, and/or unpaid balances not covered by insurance. 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. A $15.00 postage and office charge fee and $30.00 collection fee will be added to any invoice turned over to a third-party for collections.

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.

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

Patient/Parent/Guardian Signature: _____ Date: _____

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PATIENT AUTHORIZATIONS

Please give your insurance information to our front office staff so we can make a copy for our records

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: _____