WATERTOWN AUDIOLOGY
HEARING AID & BALANCE CENTER

FYZICAL Therapy & Balance Centers

PATIENT REGISTRATION FORM

Patient Name: _____ Sex: M F

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

Address: _____

Home Phone: _____ Cell Phone: _____ Occupation: _____

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

Primary Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Emergency Contact/Relationship: _____ Phone: _____

How did you hear about us? ☐ Physician ☐ Website ☐ TV/Radio ☐ Friend ☐ Facebook ☐ Mail ☐ Other_____

If the patient is a minor (under the age of 18), the parent or guardian bringing the patient will be listed as the Guarantor

Name of Person Responsible:	Date of Birth:
Relationship to Patient:	Address of Person Responsible:
Home Phone:	Social Security Number:

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:	

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PATIENT CONSENT FORM

CONSENT FOR TREATMENT: I consent and authorize my medical health provider to assess and treat me. I understand that my provider is available to explain the purpose of the assessment and treatment, and that I have the right to refuse the recommended treatment. No guarantee or assurance has been made to the results of any treatment.

HIPAA-ACKNOWLEDGEMENT OF RECEIPT: I acknowledge that I have reviewed the HIPAA Notice of Privacy Practices. Watertown Audiology and Fyzical Therapy reserves the right to revise its Privacy Notice Policy at any time and a revised copy may be obtained upon request.

RELEASE OF MEDICAL RECORDS FOR MY MEDICAL CARE OR AS REQUIRED BY LAW: I understand that it is important for my medical health providers to have access to my medical records, which will help them to safely manage my care. I consent to the release of my health records and other information related to my healthcare services for payment and healthcare and healthcare operations purposes. I agree that my healthcare records and other information may be released to Medicare, my insurance company or health maintenance organization, other payers, other providers involved in my care, payer network organizations, including accountable care organizations in which my providers participate, and the contractors and third party administrators of any of these parties.

NOTE: Records/Reports are automatically sent to your referring provider. To request records/reports be released to any other provider, please list them below:

Name: _____ Phone: _____

Name: _____ Phone: _____

DISCLOSURE OF PROTECTED HEALTH INFORMATION: I hereby give my consent to Watertown Audiology and Fyzical Therapy to use and disclose my protected health information (PHI) to carry out treatment, payment, and health care operations. I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that the organization has already taken action regarding my care. I have the right to request that Watertown Audiology and Fyzical Therapy restrict how it uses or discloses my PHI to carry out treatment, payment, and health care operations. The practice is not required to agree to all restrictions I may request, but if it does, it is bound by this agreement.

Please list below the names and relationships of family members, friends or caregivers, who have your permission to discuss your medical history and test results.

Name: _____Relationship:_____Phone:_____

Name: _____Relationship:_____Phone:_____

BY SIGNING BELOW, I AGREE TO THE ABOVE STATEMENTS.

Signature of Patient/Authorized Representative: _____ Date: _____

Printed Name: _____ Patient Date of Birth: _____

If Authorized Representative, Relationship to Patient: _____

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NOTICE OF FINANCIAL RESPONSIBILITY

- I understand that it is my responsibility to verify with my insurance plan that medical services provided by Watertown Audiology and Fyzical Therapy will be covered by my plan.
- **For minor patients (under age 18): 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 authorize Watertown Audiology and Fyzical Therapy to send bills for my medical care and treatment to my insurance company, other payor, and/or Medicare or Medicaid for payment, to the extent my insurance company, other payor, and/or Medicare or Medicaid is required to pay the bill under the terms of my insurance policy or by law.
- I request that my insurance company, other payor, and/or Medicare or Medicaid pay Watertown Audiology and Fyzical Therapy or the providers who are involved in my treatment.
- I consent to the release of my medical records by Watertown Audiology and Fyzical Therapy to my insurance company, other payor, and/or Medicare or Medicaid (and organizations working on their behalf) if necessary in order for my bills to be paid.
- I agree to pay for any charges not covered by any third party payor.
- I understand that I am responsible for any costs incurred in the collection of my account in case of default, including reasonable attorney fees and court costs. A $15 postage and office charge fee and $30 collection fee will be added to any invoice turned over to a third-party for collections.
- Worker's Compensation Claims – Any bills associated with Worker's Compensation visits will be sent to the appropriate Worker's Compensation insurance company for reimbursement. I agree that my insurance can be billed if the claim is not payable by Worker's Compensation.
- **I understand that if I do not provide accurate insurance information, a bill will be sent directly to me for payment.**

CANCELLATION/NO-SHOW POLICY:

Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Late Cancellations: Late cancellations will be considered as a "no-show".
- No-Show Policy: A "no show" is someone who misses an appointment without cancelling it within 24 hours. No-Shows inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show".
- The following are Watertown Audiology and Fyzical's "no-show" fees:
  1. CAP: $75
  2. VNG: $75
  3. Hearing Evaluation : $50
  4. Physical Therapy Evaluation: $75
  5. Physical Therapy Follow-Up Visit: $50

The "no-show" fees will not be covered by your insurance or workman's compensation, but will have to be paid by you personally before you will be able to schedule another appointment. In the event you have three "no-shows"/ cancellations, all remaining appointments may be cancelled and you will be referred back to your primary care/referring physician for future medical care.

BY SIGNING BELOW, I AGREE TO THE ABOVE STATEMENTS.

Signature: _____ Relationship to Patient: _____

Printed Name: _____ Date: _____