THE AUDIOLOGY OFFICES, LLC

Hearing Resources for the Northern Neck/Middle Peninsula

Welcome to the Audiology Offices, we want to provide excellent hearing care to you. Please tell us a little about yourself by completing as much as possible on both sides of this form.

How did you hear about us?_____

PERSONAL INFORMATION:

PATIENT'S NAME_____
FIRST MIDDLE LAST

MAILING ADDRESS_____
STREET CITY STATE ZIP

911 ADDRESS IF DIFFERENT_____
STREET CITY STATE ZIP

PEDIATRIC

TELEPHONE (HOME) _____ (WORK)_____

BIRTHDATE_____ AGE_____ MALE_____ FEMALE_____

NAME OF PRIMARY CARE PHYSICIAN _____

NAME & TELEPHONE OF GUARDIAN/PARENT_____

INSURANCE INFORMATION: Please present insurance card to be copied for your file.

DISCLAIMER: As a professional courtesy, we will submit your claim to your provider. This does not guarantee their payment for services. You accept responsibility for co-pay, deductibles, or uncovered procedures. If there is a hearing aid benefit on your policy, payment is required from the patient. We will then submit the claim to your insurance company. Upon receipt of payment from your insurance company, we will then reimburse you for the amount that the insurance company covered/paid. ***PLEASE INITIAL: _____***

INSURANCE IS IN WHOSE NAME_____

THEIR BIRTHDATE_____ THEIR EMPLOYER IS_____

PERSON RESPONSIBLE FOR PAYMENT _____

PRIMARY INSURANCE_____
NAME MEMBER # ADDRESS/TELEPHONE

SECONDARY INSURANCE_____
NAME MEMBER # ADDRESS/TELEPHONE

REASON FOR THIS VISIT: (Check All That Apply)

- ☐ Parent/Guardian Concern
- ☐ PCP Concern
- ☐ Risk Factors – Check all that Apply in Section C
- ☐ Missed/Failed hospital screening
- ☐ Equipment Failure at Hospital
- ☐ Part of a Diagnostic Process

RISK INDICATORS FOR PROGRESSIVE/LATE ONSET HEARING LOSS (Check All That Apply)

☐ Family history of permanent childhood hearing loss
☐ Stigmata or other findings associated with a syndrome known to include a sensorineural and/or or conductive hearing loss, including preauricular tag or pit/sinus and morphological abnormalities of the ear
☐ Postnatal infections associated with sensorineural hearing loss including bacterial meningitis
☐ In utero infections such as CMV, herpes, rubella, syphilis and toxoplasmosis
☐ Neonatal indicators – specifically hyperbilirubinemia at a serum level requiring exchange transfusion, persistent pulmonary hypertension of the newborn associated with mechanical ventilation, or conditions requiring the use of extracorporeal membrane oxygenation (ECMO)
☐ Head Trauma
☐ Parental or caregiver concern regarding hearing, speech, language, and/or developmental delay
☐ Syndromes associated with progressive hearing loss such as neurofibromatosis, osteopetrosis, and Usher's syndrome
☐ Neurodegenerative disorders, such as Hunter syndrome, or sensory motor neuropathies, such as Friedreich's ataxia and Charcot-Marie Toothe Syndrome
☐ Recurrent or persistent otitis media with effusion for at least 3 months

PLEASE READ AND SIGN/INITIAL: Please present insurance card to be copied for your file.

In order to keep your medical file up to date, we will be happy to provide your physician with a copy of our audiological findings. ***Please initial ONE*** ➔

Send a copy to my physician _____ (initial)

DO NOT send a copy to my physician _____ (initial)

Privacy Practice Notice: According to government law, we are required to make available to you a copy of our privacy practice notice. Your signature below acknowledges your receipt of such:

SIGNATURE_____ DATE_____

I hereby authorize Ann DePaolo, Au.D. and her associates to furnish information to my insurance carrier concerning my illness and treatment, and I hereby assign to her all payments for services rendered to my dependents or myself. I understand that I am responsible for payment.

SIGNATURE_____ DATE_____