BAYSIDE AUDIOLOGY - PATIENT REGISTRATION

Please Print and Fill in All Information so that we may complete your insurance billing. Thank You. **Today's Date:_____**

Patient Information: This section refers only to the person being treated today.

Name:	Sex: Age: Birthdate:
Address: Apt. #:	Marital Status (Check One): ____Single ____Married ____Separated ____Divorced ____Widowed
City: State: Zip:	SS#:
Home Phone:	Employer:
Alternate Phone:	Work Phone:
Driver's License No:	Email Address:

Spouse Information or Person Responsible for Payment of Bill:

Name:	Relationship to Patient:
Address:	SS#:
City: State: Zip:	Employer:
Home Phone:	Employer's Address:
Work Phone:	City: State: Zip:

Name of Closest Relative <u>NOT</u> Living with You:

Name:	Address:
Phone:	City: State: Zip:

Accident Claim and/or Workman's Compensation Claim (Please Fill In **ONLY** If Applicable**):**

Date: Time:	Place of Accident:
Type of Injury:	
Claim No:	Insurance Carrier:

Referral Information:

Who Referred You:	Attorney:
Family Physician:	Physician's Phone #:

Insurance Information: In order to bill your insurance for you, we will need to photocopy your insurance card(s). If you have coverage by more than one carrier, please supply information on both carriers so that we may bill them for you.

Primary Insurance (Name of Company):	Secondary Insurance (Name of Company):
Name on ID Card:	Name on ID Card:
ID Number:	ID Number:
Group Number:	Group Number:
Effective Date:	Effective Date:

HIPAA REGULATIONS REGARDING YOUR PRIVACY: ACKNOWLEDGEMENT FORM

I been provided an opportunity to review Bayside Audiology's Notice of Privacy Practices.

Name:_____
(Please Print Your First and Last Name)

Signature:_____

Date:_____

The Privacy Rule portion of the HIPAA regulations requires our practice to submit a copy of the Privacy Notice to each patient, both existing and new. If the patient refuses to sign the notice, this practice is not obligated to treat the patient.

- It is our office policy to call the phone numbers you have provided to set up or confirm appointments or to advise you that we have devices ready for you to pick up. If we cannot speak with you directly, we will leave a message on a recording or with the person who answers the phone. If you do not agree with the policies in this paragraph, you must advise us in writing.

- Initialing this _____ allows us to discuss your pertinent medical information with your children, spouse or caregiver as needed. We may not FAX, mail or discuss your personal medical information on the phone with any other individual or company other than the referring physician, agency or company responsible for payment, or the above mentioned family members/caregivers without your prior written consent.

DISCLOSURE

I hereby authorize Bayside Audiology to submit a claim to my insurance carrier or its intermediaries for all services and direct my insurance carrier or its intermediaries to issue payment checks directly to Jan Hankerson, dba Bayside Audiology.

I understand that **I am responsible** for all charges regardless of said insurance.

If you have NO INSURANCE, payment in full is due at time of service.

All invoices are payable upon receipt. A finance charge of 1.5% per month (18% per annum) will be charged if any invoice is not paid within 30 days and, in this event, the debt may be assigned to collection. If assigned to collections, a collection fee of 50% charged by the collections agency will be added to your debt.

I hereby authorize Bayside Audiology to release to my health care professional and/or my insurance carrier and/or person/organization responsible for payment of charges incurred as the result of seeking consultation from Bayside Audiology, all information necessary regarding services rendered.

I have read the above information and fully understand my obligation to BAYSIDE AUDIOLOGY.

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Patient Signature Date

A copy of this signature is as valid as original