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The Hearing & Balance Center, Inc.

HOURS:
Monday thru Friday:
9:00 a.m. to Noon • 1:00 p.m. to 4:00 p.m.

Welcome to The Hearing & Balance Center. We are honored that you have chosen us for your hearing healthcare needs. Our goal is to provide the highest quality care for all our patients in a timely and respectful manner. To save time at your appointment, please fill out the included paperwork and bring it with you to your appointment, along with your insurance cards and photo ID.

To accommodate our patients' needs, we are enrolled in numerous insurance programs. While it is difficult to keep track of all individual plans, as a courtesy we electronically or at times manually bill your insurance. We will then invoice you the remainder of the bill for which you are responsible. SHOULD your insurance have special requirements or restrictions which are not a covered service, and your insurance denies coverage, payment for these services rendered will be your responsibility.

If there is any reason you are not able to pay your invoice in full within 30 days, we will gladly work out a payment plan with you. If you do not pay it in full or contact the office there will be a 10% interest charge added to your account each month until paid in full.

Cancelling an Appointment: If it is necessary to cancel your scheduled appointment we ask that you call 24 hours in advance. We do understand there are exceptions, however, appointments are in high demand, and your notice will give another patient the ability to have access to timely medical care.

"No Show" Appointments: Unfortunately, "No-Shows" inconvenience those patients 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 your medical chart as a "no show". **An administrative fee of $25.00 will be billed to accounts for all "no show" appointments**. You will be sent a letter alerting you to the fact that you failed to show for a scheduled appointment and did not cancel the appointment giving 24 hours advance notice along with the bill for the administrative fee. A copy of the letter will be placed in your medical record

Return Check Fee: There is a $30.00 fee on all returned checks.

Wax Removal: There is a fee of $25.00 per ear for wax removal.

Hearing Aids Purchased Elsewhere: If you did not purchase your hearing aids from this office, there is a $50.00 PER AID charge at the first visit and $30.00 PER VISIT charge thereafter.

Third Party Buying Groups: If you are purchasing your hearing aids through a third party buying group, your first six months are included with the cost of the hearing aids. After six months, you will be charged an office visit of $30.00. Keep in mind, walk-ins are always welcome from 9-12 and 1 -4 each Monday, Tuesday and Thursday with Fridays from 9-12.

Thank You for choosing our office for your hearing and balance needs.

THE HEARING & BALANCE CENTER, INC.
Dr. Alexis Nadler, Au.D
Please fill out the registration to the best of your knowledge.
All patient information is confidential.

Patient First Name: _____ M.I.:_____ Last Name: _____

Date of Birth: _____ SSN: _____ Sex: Female Male

Street: _____ City: _____

State: _____ Zip: _____ Home Phone #: (____) _____ Cell Phone #: (_____) _____

Email Address: _____

Marital Status: _____ Employer: _____ Work Phone #: (_____) _____

Emergency Contact: _____ Relationship: _____ Phone #: (_____) _____

General Physician: _____ How did you hear about our office? _____

If you are under 18 years old, please list parents' names: _____

Who will be responsible for your account? Self Spouse Father Mother Other: _____

Name (First) _____ (Last) _____ SS#: _____ DOB: _____

Mailing Address: _____ City: _____

State: _____ Zip: _____ Home Phone #: (_____) _____ Cell Phone #: (_____) _____

Employer: _____ Work Phone #: (_____) _____

RELEASE OF MEDICAL INFORMATION:

I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits directly to the Hearing & Balance Center, Inc. for services performed. Non-covered services or services are my responsibility.

Signature of Patient: (*Parent or Guardian of minor)* X_____ Date: _____

PAYMENT OF INSURANCE BENEFITS/ FINANCIAL POLICY

We make every effort to keep down the cost of your hearing care. An estimate of the charge for any service you may require will be given to you. If you have any insurance we will be glad to fill out the proper forms. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is NOT a substitution for payment. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

The initial payment is due the day you pick up your hearing aid(s). We will call your insurance as a courtesy, but you must remember that we can only get an estimate of coverage and NOT the exact amount. If your insurance does not cover any part of the services; or if you have no insurance coverage, you are responsible for the billed amount. For your convenience we accept MasterCard and Visa, in addition to Care Credit. We will be happy to discuss these options with you.

Please note, in the event that you fail to make payment when due, this account will be referred to a collection agency. You will be responsible for all collection costs, attorney fees, and court costs.

As the patient/responsible party, I have read, understand, and agree to the terms set forth in the current Financial Policy and accept full financial responsibility for this account.

Signature of Patient: *(Parent or Guardian of minor)* X _____ Date: _____

Adult Case History Form

Patient Name _____ **Date** _____

1. Chief complaint: Hearing loss ___ (___right ___left) Tinnitus/Ringing ___
   Difficulty hearing ___ (___in quiet ___in noise)
   Dizziness/ Imbalance/ Falls ___Yes ___No
2. How long have you noticed this difficulty? _____
3. Do you feel your hearing fluctuates? ___Yes ___No
4. Have you ever been exposed to loud noise, either recently or in the past? ___Yes ___No
   If so, please mark all that apply: ___ Farm Machinery ___ Music ___ Military
   ___ Hunting/Shooting ___ Factory Noise ___ Power Tools
   Other_____
5. Have you seen an Ear, Nose, and Throat Physician? ___Yes ___No
   If so, who did you see and when? _____
6. Have you ever had surgery that may have affected your hearing? ___Yes ___No
   If so, what surgery did you have and when? Who was the surgeon?
   _____
7. Is there a history of hearing loss in your family? ___Yes ___No
   If so, who? _____
8. Have you ever had an ear infection? ___Yes ___No If yes, ___child ___adult
9. Have you, in the past 10 years, experienced chronic or acute dizziness, vertigo, or lightheadedness? ___Yes ___No If yes, please describe: _____
   _____
10. Do you currently smoke? ___Yes ___No
11. Please list your prescription medications:
    _____
    _____
    _____
    _____
    _____

---Over---

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12. Please check any of the following that you currently have or have had in the past:

___ Arthritis ___Asthma ___Bell's Palsy ___Diabetes
___Head Injury ___Heart Trouble ___Hepatitis
___High Blood Pressure ___HIV ___Malaria ___Measles
___Mumps ___Meningitis ___Neurological Symptoms
___Parkinson's ___Scarlet Fever ___Sinusitis ___Stroke/TIA
___Visual Problems

13. Please rank the following in order of importance (1-4), if a hearing aid is recommended for you:

___Improved hearing in quiet ___Improved hearing in noise
___Cosmetic appearance ___Expense

14. If you currently are using a hearing aid, or have in the past, please answer the following:

Which ear is/was aided? ___right ___left

Brand of the hearing aid(s) _____

How long have you used a hearing aid(s)? _____

What would improve your current hearing aid(s)? _____

_____

Would you like your current hearing aid(s) to be reprogrammed for a fee of $50.00?

___Yes ___No