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:** ____________________