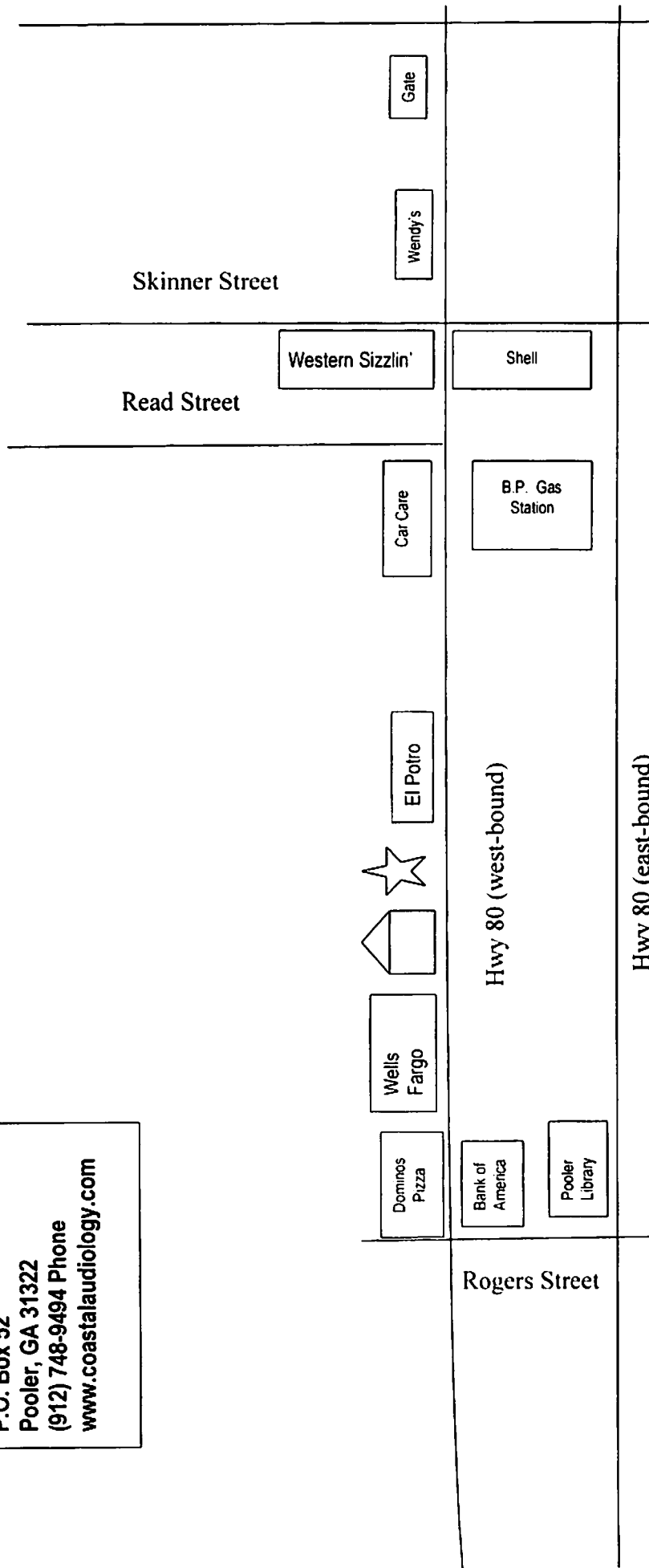


Map not to scale

Coastal Audiology
 216 E. Hwy 80
 P.O. Box 52
 Pooler, GA 31322
 (912) 748-9494 Phone
www.coastalaudiology.com



If coming from Interstate 95: Take the Pooler exit (Hwy 80), Exit number 102. If coming from the north, turn right at the bottom of the off-ramp. If coming from the south, turn left at the stop light. You will pass the Gate gas station, Wendy's, Lovezola's Pizza, Western Sizzlin', and Casrol Car Care Center on the right. You will approach El Potro Mexican Restaurant on the right. We are right behind/beside El Potro, a white building with a ramp in front. If you pass Wells Fargo Bank, you've gone too far.

If coming from Hwy 80: If coming down Hwy 80 westbound (from Bloomingdale, etc.), you should continue down Hwy 80, past Rogers Street. At Skinner Street (intersection of the BP, Special Touch Florist), turn left onto Skinner Street. At the stop sign, turn left onto Hwy 80. Western Sizzlin' will immediately be on your right. You will approach El Potro Mexican Restaurant. We are right behind/beside El Potro, a white building with a ramp in front. If you pass Wells Fargo Bank, you've gone too far.

If coming from Interstate 16: At the I-16/I-95 interchange. Take I-95 north-bound. Take the next exit, Exit 102. Turn left at the stop light. You will pass the Gate gas station, Wendy's, Lovezola's Pizza, Western Sizzlin', and Casrol Car Care Center on the right. You will approach El Potro Mexican Restaurant. We are right behind/beside El Potro, a white building with a ramp in front. If you pass Wells Fargo Bank, you've gone too far.

Alternate directions from I-16: Take Exit 155 (Sav/h/HI airport). If coming from the west (Statesboro, Pembroke), turn left at the top of the ramp. If coming from the east (Savannah), turn right at the top of the ramp. You will pass Lowe's on the right. Go through the light at Pine Barren Road. Take the next exit (Hwy 80). At the stop light, you will see a Piggly Wiggly shopping center across the street and a Clyde's Market/gas station on your right. Turn right. Continue down Hwy 80, past Rogers Street. At Skinner Street (intersection of the BP, Special Touch Florist), turn left onto Skinner Street. At the stop sign, turn left onto Hwy 80. Western Sizzlin' will immediately be on your right. You will approach El Potro Mexican Restaurant on the right. We are right behind/beside El Potro, a white building with a ramp in front. If you pass Wells Fargo Bank, you've gone too far.

PEDIATRIC PATIENT INFORMATION

Date: _____ Child's Name: _____ Name child is called _____

Age: _____ Date of Birth: _____ Sex: _____

Mailing Address: _____
City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone# (if any): _____

May we leave a message? Yes _____ No _____ With whom? _____ On machine? _____

School: _____ If Tricare, Sponsor's Name _____
If Tricare, Sponsor's SSN _____

Mother's Name: _____ Work Phone: _____
Father's Name: _____ Work Phone: _____

Brief explanation of why child is here today: _____

Currently wears hearing aids? _____ If so, which ear? R _____ L _____ Both _____
If yes, what type of aids are worn? _____ How long? _____

Primary Insurance: _____ Phone: _____
Secondary Insurance: _____ Phone: _____

How did you hear about us? _____

Pediatrician: _____ Phone: _____
Doctor/Facility that referred you to our Office? _____

Has child ever seen an ENT Physician? _____ If yes, who? _____
If so, what were they seen for? _____

Has the child ever had their hearing tested? _____
If so, where and why? _____

Is child on any medications, including vitamins and/or supplements? If so, for what purpose?

ASSIGNMENT OF BENEFITS-RELEASE OF INFORMATION

By signing below, I certify that the above information is true and correct to the best of my knowledge. I hereby assign all insurance benefits to which I am entitled, including Tricare, Medicaid, private insurance, and any other health plans to Coastal Audiology. The assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information that is necessary to secure payment. *If you have not met your required deductible for the year, you will be responsible for the remaining charges after insurance has been billed.*

GUARDIAN'S SIGNATURE _____ DATE _____

Premature membrane rupture YES NO Other _____

Was a Newborn Infant Hearing Screening Test Performed at birth? _____

If so, did the child pass? _____ If not, has the child been rechecked? _____

NEWBORN FACTORS

Birth weight less than 5 pounds YES NO If yes, specify birth weight: _____
APGAR score low at birth YES NO If yes, APGAR score if known: _____
Placed in intensive care YES NO If yes, specify how long: _____
Breathing problems at birth YES NO
Oxygen given at birth YES NO If yes, specify how long: _____
Bilirubin > 15mg/100ml YES NO
Congenital rubella YES NO
Defects of ear, nose, throat YES NO If yes, specify: _____
Congenital heart disease YES NO
Drugs given (inc. antibiotics) YES NO If yes, specify: _____
Exposure to chemicals YES NO If yes, specify: _____
Paralysis at birth YES NO
Seizures at birth YES NO
Septicemia YES NO

INFANT / CHILDHOOD FACTORS

Eye problems YES NO If yes, specify: _____
Balance/gait/dizziness problems YES NO Cerebral Palsy YES NO
Seizures YES NO Head/skull injury YES NO

CHILD EVER HOSPITALIZED FOR / DIAGNOSED WITH / TREATED FOR:

Meningitis Encephalitis Measles Influenza (Flu) Cytomegalovirus (CMV)
Chickenpox Septicemia Diabetes Sickle Cell Rubella
Other _____

HISTORY OF EAR PROBLEMS

Ear infections: NONE LEFT RIGHT BOTH If yes, specify what ages, how many and how often: _____

When was last ear infection: _____

Ever had "tubes" in ears? NONE LEFT RIGHT BOTH Specify when & how many times: _____

If so, who performed the surgery? _____

Is the child currently being treated for any medical condition, including, but not limited to ear infections, tonsillitis, swollen glands, allergies, sinus infections, etc? If so, please explain _____

By signing below, I certify the above information is true and correct to the best of my knowledge

Signature _____ Date _____

FINANCIAL AGREEMENT

We participate in many different insurance plans. We will file your insurance claims for the companies with whom we are contracted. You will be responsible for any co-payments or deductibles at the time services are rendered. For some other insurance, we accept assignment of benefits, but in all cases, we require that the guarantor, the person who is financially responsible, is personally liable for all balances not covered by insurance. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. It is your responsibility to notify us if your insurance has changed and to provide us with your new insurance card if one has been issued. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically-necessary under the Medicare program or by other medical insurance companies. Our professional services are rendered to you, not your insurance company, therefore payment for treatment is ultimately your responsibility. You will be responsible for co-payments, deductibles, out-of-network amounts or any portion your insurance company states you are responsible for. Payment for co-pays are expected at the time of service. If this fee is not covered by insurance, it will be your responsibility. We allow your insurance company 45 days to pay your claim. If we do not receive payment in 45 days, you will be given a bill at that time. For our HMO/PPO patients, if we are contracted with your HMO/PPO company, you will not receive a bill until we have heard from your insurance company. You will be responsible for any and all reasonable costs associated with collection, including filing fees as well as reasonable attorney's fees should this account be turned over to collections for non-payment. We reserve the right to charge a \$35 fee for no-show, no-call cancellations or cancellations made without 24 hours notice. This fee cannot and will not be paid by your insurance company. We reserve the right to not provide service to you for any unpaid balance owed on your account that is more than 30 days past-due.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment to Coastal Audiology, Inc. and/or Dr. Dawn Hostetler-MacMillan, Audiologist (provider of services) of any insurance or health benefits otherwise payable to or on behalf of the patient for examination, treatment, or devices delivered to me by Coastal Audiology, Inc. and its representatives, at the rate not to exceed Coastal Audiology's usual charges. I understand that verification of insurance coverage obtained over the phone, fax, or online is estimated and does not guarantee payment and that insurance coverage is a relationship between the patient and his or her insurance company(s). I agree to accept financial responsibility for any charges for goods or services rendered to the patient that are not paid by insurance or health benefit plan pursuant to this assignment of benefits. I have been informed that Medicare does not provide payment for hearing aids, other assistive listening devices or fitting examinations. This also applies to most Medicare 'supplement' policies.

RELEASE OF INFORMATION:

I hereby authorize Coastal Audiology to release any medical information about the patient necessary to determine liability for payment and to process any claim for examination, treatment, or devices received by the patient. I also authorize Coastal Audiology to release the medical records of the patient to the patient's referring physician or family physician indicated within this document.

I have read and agree to the terms above and verify that the information provided is true and correct to the best of my knowledge.

Signature of Patient or Legal Representative

Date

HIPAA Notice of Privacy Practices

Coastal Audiology, Inc. has a policy of complying with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our objective is to be 100% compliant at all times. The following method of operations will be used to insure privacy of a patient's Protected Health Information (PHI).

1. Based on HIPAA guidelines your medical records may be transferred to another care provider upon your signed authorization. Records will not be transferred without your or your guardian's signed authorization.
2. You may review your records by scheduling a time with our office.
3. After review of your records if you disagree with any of the documentation in the records you have the option of writing your own documentation to be placed in the chart.
4. If an appointment with another medical provider is required, only the necessary information to schedule an appointment will be provided.
5. If you elect not to allow any other member of your family access to your records you have the right to notify our office. That notice must be in writing. If you wish to provide access to your records to a designated individual, you may also provide that in writing or in the space below.
6. Our office will not provide any information about you or your medical condition to any other party other than other medical providers to whom you have been referred for treatment without your specific authorization.
7. If you are chosen or volunteer to be a part of any research program you will be required to sign additional authorizations and releases so that your PHI may be used in the program.
8. Under HIPAA rules, we may use the necessary PHI from your medical records to file insurance claims on your behalf. Your authorization and insurance assignment allows the practice to file insurance on your behalf.
9. There will be certain circumstances where public health authorities and health oversight agencies may require a copy of your records. They are authorized under law to collect that information and we are required to furnish a copy of your PHI.
10. All efforts will be taken to ensure that your PHI will not be shared with any unauthorized persons.
11. If you are on active duty military or are called to active duty military, under federal law we are required to supply you with a copy of your record upon request.

If you have any questions concerning any of the above statements or wish to receive a signed copy, please ask.

Patient Signature (or guardian)

Date

I wish to allow the person(s) below access to my medical records: