



Directions:

From Hwy 80, take Pooler Parkway towards Wal-Mart. You will see Monster Storage on the right. The street just past Monster Storage is Pipemaker's Circle. Turn right on Pipemaker's Circle. Approximately 1/2 block on the left is Canal Street. Turn left onto Canal Street. Immediately to the right, turn into Pooler Park Office Center. We are Bldg. 1, suite 108 on the end downstairs.

or

From I-95, take the Savannah/Hilton Head Airport exit (Exit 104). Go West, past Wal-Mart and Home Depot (away from the airport). Go approximately 1 mile and start looking on your left for Regions Bank and Cancun Mexican Restaurant, at the corner of Pooler Parkway and Park Avenue. (This is the entrance to the Pooler Park of Commerce.) Turn left onto Park Avenue. Turn right onto Canal Street. (This road runs parallel to Pooler Parkway.) Near the end of Canal Street you will see Pooler Park Office Center on the left. Turn into the parking lot. We are located in Bldg. 1 (immediately to the right), downstairs, in Suite 108.

or

From I-16, take exit 155. (From I-16 East, turn left off of the ramp. From I-16 West, turn right off of the ramp.) Go approximately 3 miles and you will see Monster Storage on the right. The street just past Monster Storage is Pipemaker's Circle. Turn right on Pipemaker's Circle. Approximately 1/2 block on the left is Canal Street. Turn left onto Canal Street. Immediately to the right, turn into Pooler Park Office Center. We are Bldg. 1, suite 108 on the end downstairs.

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 Policy

PLEASE PRESENT YOUR INSURANCE CARD(S) AND A PHOTO ID

Payment for services is due at the time services are rendered. We require that patients update their personal information with each visit. If changes have been made with your insurance company or any other personal information, please let us know upon your arrival at our office. Failure to do so could result in a denial of payment by your insurance company. If your insurance plan requires a paper referral, please bring the referral with you. It is your responsibility to keep your referral current.

If you are insured through one of the HMO/PPO listed, we file directly for reimbursement. If your plan is not listed, please check with our office to confirm participation. This list is updated frequently.

AETNA
AMERIGROUP
BLUE CROSS/BLUE SHIELD OF GEORGIA
COVENTRY/SOUTHCARE
MEMORIAL HEALTH – CBCA
ST. JOSEPH'S/CANDLER - THE CARE NETWORK

TRICARE
UNITED HEALTH CARE
MEDICARE
MEDICAID
WELLCARE
PHCS

All co-payments or deductibles will be collected at the time of service. It is the patient's responsibility to show proof of the insurance deductible being met. **IF YOU ARE A MEDICARE PATIENT, YOU ARE SUBJECT TO YOUR 20% COPAY AT THE TIME SERVICES ARE RENDERED, UNLESS YOU HAVE A SECONDARY INSURANCE OR MEDICARE SUPPLEMENT. WE CANNOT BILL YOU FOR THIS.**

Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract. Not all services are covered benefits in all contracts. Some companies arbitrarily select certain services that they will not cover or will only partially cover. Please remember that our professional services are rendered to you, not the insurance company, therefore payment for treatment is your responsibility. We allow 90 days for reimbursement from insurance companies. After 90 days the balance will become your responsibility.

I understand that I am directly and fully financially responsible to my Audiologist for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgment or insurance payment by which I eventually recover said fee. I realize that any co-pays, deductibles or procedures not covered by my insurance company are my responsibility and must be paid at the time of my visit.

I further understand and agree that if I fail to make timely payment on my account, I will be responsible for any and all reasonable cost of collection, including filing fees as well as reasonable attorney's fees.

There is a \$35.00 charge for the cancellation of an appointment with less than 24 hours notice.

SIGNATURE

DATE

*****PLEASE READ & SIGN REGARDLESS OF
THE REASON FOR YOUR APPOINTMENT!*****
HEARING DEVICE FINANCIAL AND ADJUSTMENT PERIOD POLICY

Deposits

We require a minimum 50% deposit on all hearing aid purchases and repairs. If you are unable to do so, please speak with a member of our staff so we can make other arrangements. Finance options are available, as well as assistance programs for those who qualify. We will make every effort to accommodate you and not let price stand in the way of better hearing. Hearing instruments that are ordered and are not fit within 30-days will be returned to the manufacturer and your 50% deposit will be forfeited.

Insurance

Additionally, most insurance companies DO NOT cover hearing aids. If they do, it is typically a very small amount that will not cover the total cost. If you do have hearing aid benefits, we require full payment up front and we will then give you the necessary paperwork in order for you to file your claim independently. If you prefer not to pay the total cost up front, we will gladly file with your insurance company and once payment is received from both the insurance company as well as your portion of the balance owed, we will happily order your hearing aid(s). *We encourage you to carefully read 'the fine print' in your insurance contracts, as the terminology can be misleading and confusing.* Medicare will not cover hearing aids. Supplemental insurance that is a "Medicare Supplement" will not cover hearing aids, as they typically fall under the same guidelines as Medicare.

_____ (initial) **Coastal Audiology, Inc. offers a 30-day adjustment period with each hearing device we fit, beginning on the day of the fitting.** At the end of your thirty days, should you decide to return the hearing devices, you will be refunded the purchase price of your hearing devices minus a \$500 professional service fee. This service fee covers the time involved in selecting, fitting, and adjusting the hearing device(s), shipping/ handling, custom earmolds and/or hearing aid shells, as well as other costs associated with returning a hearing device to the manufacturer.

We at Coastal Audiology are certain that we can successfully fit individuals with hearing loss with the appropriate hearing aids if that patient

- ✓ *has realistic expectations*
- ✓ *is motivated to hear better*
- ✓ *is patient enough to allow the delicate hearing mechanism time to adjust to a new world of sound. Hearing loss typically doesn't occur overnight---we certainly cannot expect 'perfect' hearing after just a few short weeks after wearing hearing aids. Hearing will never be 'perfect'.*

We ask that you give us the courtesy of our time and expertise to make this an exciting and successful adventure for all of us.

Kind Regards,

Dawn Hostetler-MacMillan, M.S., CCC-A
Certified and Licensed Audiologist

By signing below, I certify that I understand the above statement.

Patient (or Guardian) Signature

Date

*****You will NOT be seen if this form is not signed and dated!!!*****

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 the 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 to not 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 notice in writing.
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 to be 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 the 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 a copy of your record.

If you should have any questions concerning any of the above please contact any of the staff at Coastal Audiology, Inc.

PLEASE SIGN AND DATE BELOW:

Signature

Date