Bridgewater
Balance & Hearing

Registration and Consent

Social Security Number: _____ - _____ - _____

Last Name: _____ First Name: _____ MI: ____

Preferred Name: _____ Date of Birth: _____ Age: _____

Sex: Male/Female **Home Phone: (_____)_____-_____Cell Phone: (_____)_____-_____**

Work Phone: (_____)_____-_____ **Email Address: _____**

Street Address: _____

City: _____ County: _____ State:_____ Zip: _____

Who may we contact in case of an emergency?_____ Phone: (_____)_____-_____

Who may we thank for referring you to Bridgewater? _____

Who is financially responsible for the bill? _____ Phone: (_____)_____-_____

I authorize Bridgewater Balance and Hearing, Inc. to release information requested with regard to processing my claims. Yes **or** No

I authorize Bridgewater to disclose any or all parts of my protected health information to the individuals listed below. I acknowledge this with my signature within the Patient's Benefit Assignment, Privacy Notice, and Contact Authorization below:

Contact Preference: ____Confidential ____ Do NOT call ____Okay to Leave Message ____E-Mail

The evaluation and treatment procedures by Bridgewater clinicians are professionally and ethically acceptable and offer no probable physical or psychological risk. Although procedures are expected to be of benefit, I understand that no guarantee of success can be expressed or implied. I agree to the scheduled procedures and understand I may discontinue the evaluation or treatment at any time.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. All registration information is correct to the best of my knowledge. I will notify Bridgewater Balance and Hearing, Inc. should the above information change.

Privacy Notice: I confirm that I have been given a copy of the Bridgewater Balance and Hearing's Notice of Privacy Policies and understand my privacy rights.

Signature: _____ Date: _____

Guardian Signature (if Patient is a minor): _____

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Financial Responsibility for the Cost of Services

Insured Name (Print Clearly): _____ Insured's Date of Birth: _____

Please List Primary and Secondary Insurances Below:

Primary Insurance Company Name	**Member ID Number**	**Date of Birth**
Secondary Insurance Company Name	**Member ID Number**	**Date of Birth**

Name of Primary Care Physician: _____

Services Requested: Auditory, Vestibular, and/or Diagnostic Evaluations

I know that commercial and state sponsored insurances pay for healthcare. I know when I get health care, my doctor sends the charges to my insurance company for payment. I know I must show my ID card to all doctors and hospitals before I get health care. I know a copayment is when I have to pay part of the bill each time I receive certain health care services. **I know that it is my responsibility to get all insurance authorizations in advance.**

Please initial each statement below that applies to you:

_____ **I have Medicare, Medicaid, or TENNCARE. I asked for one or more of the health care service(s) listed below. I understand my insurance may not pay for it.**
***A physician referral is REQUIRED to bill Medicare.**

_____ **I have private commercial insurance. I asked for one or more of the health service(s) listed below. I understand my insurance may not pay for it.**

My doctor has told me how much of the health care service(s), listed below, I may have to pay.
Balances listed below may be added to any applicable deductibles. I must pay my balance in a timely manner in order for the discounted amount to remain in force.
The patient is also responsible for any balance listed as patient responsibility.
This is a legal and binding contract.

Service	Cost of Service	Patient Balance is NOT to Exceed:
Specialist New Patient Office Visit	$125.00	$125.00
Audiometric (Hearing) Evaluation	$335.00	$215.00
Auditory Processing (APD) Evaluation	$1275.00	$595.00
EcochG and ABR Evaluation	$850.00	$395.00
VNG Evaluation	$1200.00	$595.00
Hearing Instruments**	As Indicated	The patient agrees to pay all balances.

** If you request that Bridgewater Balance and Hearing bills your insurance company for hearing instruments, the PATIENT is responsible for all hearing aid balances over the *actual insurance reimbursement amount* of the devices.
** If you request that Bridgewater Balance and Hearing files your claim, provider write-off and discount amounts are NOT applicable on hearing instrument purchases.
** Patients that choose to purchase hearing instruments that EXCEED the amount of insurance coverage on their plan do so with the understanding that they agree to pay ALL BALANCES over the *actual insurance reimbursement amount*.

By signing this paper, I agree to pay for the services listed above in a timely manner.

Printed Name of the Responsible Person	**Signature of Member or Responsible Person**

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Record Release

I authorize Bridgewater Balance and Hearing to issue my hearing healthcare information to:

___ Physician(s): _____

___ Insurance Company: _____

___ Other(s): _____

Patient Signature: _____ Date: _____

Release of Records from Another Healthcare Provider

I authorize a release of my hearing and balance records to Bridgewater Balance and Hearing from:

_____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Please Fax Records to:

____ Knoxville Office at (865) 769-0281

____ Sevierville Office at (865) 429-0719

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Please Provide a List of Your Current Medications

Medication	Dosage	Frequency	Route (e.g., via mouth)

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Confidential Patient History

Patient's Name: _____ **Date:** _____

MEDICAL HISTORY

Yes	No	Have you seen a doctor in the past 6 months? If yes, who have you seen? _____
Yes	No	Have you seen a doctor specializing in diseases of the ear (e.g., ENT)? If yes, who have you seen? _____ When?_____
Yes	No	Have you ever had your hearing tested? If yes, give a date: _____ by whom? _____
Yes	No	Do you have a heart condition? If yes, please explain: _____
Yes	No	Do you have a pacemaker of defibrillator?
Yes	No	Do you have any significant medical conditions (e.g., high blood pressure)? If yes, explain: _____
Yes	No	Do you take medicine every day? If yes, explain for what conditions: _____
Yes	No	Have you ever had any type of ear surgery or trauma? If yes, explain: _____
Yes	No	Have you had head trauma? If yes, explain: _____
Yes	No	Do you use tobacco in any form?
Yes	No	Do you experience significant sinus and/or allergy issues?

ABOUT YOUR EARS

Yes	No	Deformity of the ear	If yes, which ear(s)? BOTH RIGHT LEFT
Yes	No	Tinnitus (ringing or buzzing in the ear)	If yes, which ear(s)? BOTH RIGHT LEFT
Yes	No	Fullness or stuffiness of the ear	If yes, which ear(s)? BOTH RIGHT LEFT
Yes	No	Pain in your ear	If yes, which ear(s)? BOTH RIGHT LEFT
Yes	No	Drainage from the ear (aside from ear wax)	If yes, which ear(s)? BOTH RIGHT LEFT
Yes	No	Acute or chronic dizziness	
Yes	No	Sudden or rapid change in your hearing sensitivity	
Yes	No	Excessive ear wax requiring removal by a physician	
Yes	No	Extreme sensitivity to loud sounds	

ABOUT YOUR HEARING

Yes	No	Are you concerned that you have hearing loss? If yes, for which ear(s): BOTH RIGHT LEFT If yes, how long have you had difficulty hearing? _____ If yes, which is your poorer ear? SAME RIGHT LEFT
Yes	No	Does anyone in your family have a hearing problem? If yes, what relationship? _____
Yes	No	Do you or have you ever worn a hearing aid? If yes, how do you think you may be helped? _____
Yes	No	Do you have difficulty understanding conversations in quiet?
Yes	No	Do you struggle to understand speech in the presence of background noise?
Yes	No	Do you have difficulty hearing on the telephone?
Yes	No	Have you been exposed to loud noises (e.g., gunfire, explosions, power tools, factory noise, machinery, lawn equipment, loud music, etc.)?
Yes	No	If yes, did you wear hearing protection?

Signature or Guardian Signature: _____ **Date:** _____