Bridgewater
Balance & Hearing

103 Suburban Rd, Suite 101-D
Knoxville, TN 37923
865-769-0283

117 S Charles Seivers #202
Clinton, TN 37716
865-269-4607

1240 Fox Meadows Blvd, Ste 5
Sevierville, TN 37862
865-453-3892

4010 Fountain Valley Dr, Suite 5,
Knoxville, TN 37918
865-377-4980

169 Westmoreland Street
Harrogate, TN 37752
865-769-0283

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Registration Form

Patient Name:	DOB:	Age:
Preferred Name:		
Street Address:		
City:	State:	Zip:
Social Security #:	Gender: ☐ **Male** ☐ **Female**	

Social Security # of Responsible Party/Insured:	DOB:
Address of Guarantor, if different:	

Home Phone:	Work Phone:	Cell Phone:	Carrier:
Email Address:		Spoken Language: **English Spanish Other**	
Marital Status: **Single Married Separated Divorced Widowed**		Name of Spouse, *if applicable*:	
If child, please list the name of the custodial parent/guardian:			
Employer: **Part-Time Full-Time Retired**			
Occupation:			
Emergency Contact:	Relationship to Patient:	Phone #:	
Referring Physician Name:		Phone #:	
Primary Care Physician Name:		Phone #:	
Who may we thank for referring you to Bridgewater?			
Who is financially responsible for the bill?		Phone #:	
Contact Preference: ☐ **Confidential** ☐ **Do Not Call** ☐ **OK to Leave Message** ☐ **Email**			

Would you like us to send a copy of your current and future test results and/or reports to (please check all that apply; by checking the box and listing below you are authorizing Bridgewater to communicate with these entities regarding your healthcare and treatment):

- ☐ **Referring Physician**
- ☐ **Primary Care Physician**
- ☐ **Other Physician**
- ☐ **School**
- ☐ **Family Member**
- ☐ **Other**

Signature: _____ **Date:** _____

Guardian Signature *(if Patient is a minor)*: _____ **Date:** _____

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Medical History

Major illnesses, cancer, surgeries, injuries, or hospitalizations since birth and their approximate date(s) of occurrence: _____

_____

Allergies (food, medications, plastics, etc.): _____

Have you experienced any of the following major medical conditions (please check all that apply):

☐	AIDS/HIV	☐	High Blood Pressure
☐	Arthritis	☐	High Fevers
☐	Blood Disorders	☐	Influenza
☐	Cancer	☐	Malaise
☐	Chicken Pox	☐	Malaria
☐	Depression	☐	Measles
☐	Diabetes	☐	Meningitis
☐	Diphtheria	☐	Mumps
☐	Encephalitis	☐	Scarlet Fever
☐	Fatigue	☐	Stroke
☐	Genetic Disorders	☐	TMJ
☐	Headaches	☐	Typhoid
☐	Head Injury	☐	Vascular Problems
☐	Heart Problems	☐	Other_____

PLEASE COMPLETE MEDICATION SECTION IN ITS ENTIRETY:
Do you take medications (prescription of over-the-counter) or vitamins/supplements on a regular basis?

MEDICATION	DOSAGE	FREQUENCY	ROUTE (e.g., via mouth)	Reason Taken

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Office and Financial Policies

Thank you for choosing Bridgewater Balance and Hearing for your hearing healthcare needs. We are committed to you and your improved hearing and balance. We also want your experience with us to be a positive and productive one. To that end, we want to take this opportunity to inform our patients and their families of our payment policies. This knowledge will help you be better prepared for your appointment.

Bridgewater is a participating provider with most all insurance carriers in the area. We can assist you in determining whether or not we are a participating provider for your insurance plan. Insurance coverage is an agreement between you and your insurance carrier. We, as healthcare providers, just execute that agreement for you. As a result, it is your responsibility to determine whether or not you have out of network benefits (if Bridgewater is not a participating provider in your insurance plan) and whether or not you require prior authorization or a referral prior to services being provided or if audiology services and/or hearing aids are covered through your plan. It is important to gather this information prior to your appointment with us. Bridgewater cannot submit a claim to any insurance carrier if we do not have all required orders, referrals, or prior authorizations on file, when needed. They cannot be obtained after the service is provided. If you are unsure of your coverage specifics, please bring your member benefits handbook with you to the appointment.

Insurance carriers often do not cover, in full, all goods and services. While we will verify coverage specifics with your insurance carrier as needed, please understand that these are NOT a guarantee of coverage or payment. There may be situations where your insurance carrier does not cover the specific good or service you are requesting. Bridgewater commits to providing quality, professional hearing healthcare to all its patients, regardless of their circumstance. When required and possible, we will work to offer an item or service that is within the limits of your insurance coverage.

It is very important that you inform us within 24 hours of your appointment if you need to cancel or reschedule. While we realize that emergencies do occur, Bridgewater reserves the right to charge up to a $125 cancellation fee for all no-show appointments or appointments canceled with less than a 24 hour notice.

We understand that sometimes you may be running late to your appointment. Unfortunately, we have patients scheduled throughout the day and may not be able to see you if you arrive more than 15 minutes after your scheduled appointment time. We will try to accommodate you if time allows. Otherwise, we will need for you come back later in the day if a later appointment is available or reschedule to another date and time.

Your co-payment will be collected at the time the diagnostic services are provided and balances will be billed after Bridgewater has obtained an explanation of benefits from your insurance. All hearing aid related charges must be paid on the date you take possession of the aid, accessory, or supply. Bridgewater accepts payment in the form of cash, checks, Visa, MasterCard, and Discover. There will be a $30 fee for all bounced or returned checks.

It is also the policy of Bridgewater that we maintain a credit card number on file when/if a payment plan has to be arranged. This allows us to bill you for an outstanding balance that is not collected within 120 days of the date you were initially billed, while continuing to provide you with care. We will not bill any charge to your credit card without first informing you of this in writing. You then have the right to use an alternate form of payment if you so choose.

It is important that each patient accepts and meets their financial obligations to this practice. Otherwise, we will be unable to provide care to any of our patients. Bridgewater reserves the right, following 120 days of the initial invoice date, to forward all outstanding balances to either a third-party collection agency and/or small claims court. We also reserve the right to discontinue care or service to patients who have not met their financial obligations to us

_____ **I request Bridgewater Balance & Hearing submit a claim to my insurance company on my behalf, for services provided. I am aware insurance may not cover services provided, and I am financially responsible for the balance.**

Patient Signature: _____ **Date:** _____

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Advance Beneficiary Notice of Noncoverage (ABN)
MEDICARE ONLY

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost:
Office Visit	Medicare will not pay audiologists for an office visit. We will submit charges to your secondary insurance.	$125
Hearing Aids	Not a covered expense	

WHAT YOU NEED TO DO NOW:

Read this notice, so you can make an informed decision about your care.

Ask us any questions that you may have after you finish reading.

Choose an option below about whether to receive the **D.** listed above.

NOTE: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.
☐ **OPTION 1:** I want the **D.** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐ **OPTION 2:** I want the **D.** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**
☐ **OPTION 3:** I don't want the **D.** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. SIGNATURE:	J. DATE:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid 0MB control number. The valid 0MB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

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Hearing/Balance History

MEDICAL HISTORY

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

ABOUT YOUR EARS

	YES	NO		BOTH	RIGHT	LEFT
Deformity of the ear	☐	☐	If yes, which ears(s)?	☐	☐	☐
Tinnitus (ringing or buzzing of the ear)	☐	☐	If yes, which ears(s)?	☐	☐	☐
Fullness or stuffiness of the ear	☐	☐	If yes, which ears(s)?	☐	☐	☐
Pain in your ear	☐	☐	If yes, which ears(s)?	☐	☐	☐
Drainage from the ear (aside from ear wax)	☐	☐	If yes, which ears(s)?	☐	☐	☐
Acute or chronic dizziness	☐	☐				
Sudden or rapid change in your hearing sensitivity	☐	☐				
Excessive ear wax requiring removal by a physician	☐	☐				
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	☐	☐
Does anyone in your family have a hearing problem? If yes, what relationship? _____	☐	☐
Do you or have you ever worn a hearing aid? If yes, how do you think you may be helped? _____	☐	☐
Do you have difficulty understanding conversations in quiet?	☐	☐
Do you struggle to understand speech in the presence of background noise?	☐	☐
Do you have difficulty hearing on the telephone?	☐	☐
Have you been exposed to loud noises (e.g. gun fire, explosions, power tools, factory noise, machinery, lawn equipment, loud music, etc.)?	☐	☐
If yes, did you wear hearing protection?	☐	☐

Patient/Guardian Signature: _____ **Date:** _____

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