



aaiaudiology.com
Patient Registration

06/04/2025

Please complete this registration packet and bring to your appointment along with insurance cards and photo ID. Referrals and co-payments are due at the time of your visit.

First Name: _____ MI: _____ Last Name: _____
Date of Birth: _____ Nickname/Preferred Name: _____
OPTIONAL: Preferred Pronouns: _____
Parent/Guardian Full Name (if under 18): _____
Social Security #: _____ (not applicable under 18) Male: ☐ Female: ☐
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____
Preferred Method of Contact (mark one): ☐ Home Phone ☐ Cell Phone including Text Message ☐ Email

Patient's Profession: _____
Patient's Employer: _____ Phone: _____
Employer Address: _____

Emergency Contact: _____ Relationship: _____
Phone: _____ Alternate Phone: _____

Person Responsible for Payment: _____
Driver's License #: _____ SS#: _____

ALL INFORMATION IS REQUIRED IN ADDITION TO COPY OF CARD(S)

Primary Insurance: _____ ID #: _____ Group #: _____
Secondary Insurance: _____ ID #: _____ Group #: _____
Is the patient the insurance subscriber? (☐ YES – Skip to physician info (☐ NO – Please complete info below:
Subscriber's Name: _____ Relationship: _____
Subscriber's DOB: _____ SS#: _____
Address if different from patient: _____
Subscriber's Employer: _____
Employer Address: _____
City: _____ State: _____ Zip Code: _____

Primary Care Physician: _____
Address: _____
Phone: _____ FAX: _____

Other relevant physicians (i.e. ENT, Neurologist): _____
Do we have your permission to send a report to the physician(s) listed above (recommended): ☐ Yes ☐ No

Is there anything we should know about your culture, beliefs, or religious practices that would help us take better care of you? NO YES If YES, please note briefly. Your audiologist will discuss further during your appointment.

Whom may we thank for referring you? _____

PLEASE READ, COMPLETE, AND SIGN THE PRIVACY AND FINANCIAL POLICY FORMS INCLUDED IN THIS PACKET

Child History Form

Revised 4/25/2025

Patient Name: _____ DOB: _____ Today's Date: _____

Person Completing Form: _____ Relation to Child: _____

1. Why are we seeing your child today? _____
2. Do you suspect hearing loss? ☐ Yes Which ear? _____ ☐ No
3. Does your child have any medical issues or syndromes? ☐ Yes ☐ No
Please explain: _____
4. Does your child have any other diagnosed co-morbidities? ☐ Yes, Explain _____ ☐ No
(Ex: attention deficit disorder, auditory processing disorder, dyslexia, autism spectrum disorder, etc)
5. Referred due to failed hearing screening at hospital, pediatrician's office, school? ☐ Yes ☐ No
a. Which ear? _____
6. Pain or tugging from ears? ☐ Yes Which ear? _____ ☐ No
7. History of middle ear infections? ☐ Yes Treated with: ☐ Medication ☐ PE Tubes ☐ No
Date of last middle ear infection: _____ Which ear(s): _____
8. History of PE tubes? ☒ Yes When? _____ Which ear(s): _____ ☐ No
9. Congestion or Allergies? ☐ Yes ☐ No Recent cold or influenza? ☐ Yes When? _____ ☐ No
10. Medications-please list: _____
11. Family history of childhood (non-age-related) hearing loss? ☐ Yes Who? _____ ☐ No
12. Birth or delivery complications? ☐ None ☐ Jaundice ☐ Premature ☐ Illness
☐ NICU ☐ Ventilator ☐ C-Section ☐ Other _____
13. a. Hospital or place of birth? _____ b. Full-term? ☐ Yes ☐ No
14. Previous hearing screening evaluation results: _____
15. Has your child ever tested positive for COVID-19? ☐ Yes When? _____ ☐ No
Was the child's mother diagnosed with COVID-19 during pregnancy? ☐ Yes ☐ No
16. Has the child or anyone living with the child travelled internationally in the past year? ☐ Yes ☐ No
17. Is the child up to date on vaccinations, including the measles vaccine? ☐ Yes ☐ No

Infants Only (age 0 to 3)

1. Responsiveness to Auditory Stimuli? ☐ Yes ☐ No
2. Localization Abilities? Does he/she look for the source of sounds? ☐ Yes ☐ No
3. Does he/she startle to loud noises? ☐ Yes ☐ No
4. At which age (months/years) did he/she achieve the following milestones?
Sitting Up _____ Crawled _____ Walked _____ First Word(s) _____
5. Speech/Language Delays? ☐ Yes ☐ No
6. Developmental Delays? ☐ Yes ☐ No
7. a) Early intervention, speech or other therapy? ☐ Yes ☐ No
7. b) Describe the therapy/intervention/frequency: _____

Children Only (age 4 to 10)

1. Speech/Language Delays? ☐ Yes ☐ No
2. Developmental Delays? ☐ Yes ☐ No
3. School/Academic Performance? ☐ Below Average ☐ Average ☐ Above Average
4. Diagnosis for Attention Deficits? ☐ Yes ☐ No
5. a) Early intervention, speech or other therapy? ☐ Yes ☐ No
5. b) Describe the therapy/intervention/frequency: _____

Adolescents Only (age 10 and up)

1. Ringing or noises in ears? ☐ Yes Which ear(s)? _____ How long? _____ ☐ No
2. Speech/Language Delays? ☐ Yes ☐ No
3. Developmental Delays? ☐ Yes ☐ No
4. School/Academic Performance? ☐ Below Average ☐ Average ☐ Above Average
5. a) Early intervention, speech or other therapy? ☐ Yes ☐ No
5. b) Describe the therapy/intervention/frequency: _____
6. Noise exposure without hearing protection and/or use of earphones regularly ☐ Yes ☐ No



Audiology Associates, Inc.

Health Information Privacy and Affordability Act (HIPAA) Packet

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

- This Notice informs me how Audiology Associates, Inc. will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Audiology Associates, Inc. may use and share my health information for other than treatment, payment, and health care operations.
- Audiology Associates, Inc. will also use and share my health information as required/permitted by law.
- I acknowledge that I received a copy of Audiology Associates Inc.'s Notice of Privacy Practices.
- I consent to receive text/email appointment reminders and Google notifications
- I further acknowledge that a copy of the current notice is posted in the reception area and on our website and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment if amended.
- Copies of requested health records will be supplied within 15 days or less from the request date
- Medical records are subject to a \$0.57 per page plus postage and handling charge

I consent to Audiology Associates Inc. releasing protected health information as detailed above. Please list names of FAMILY or PERSONAL REPRESENTATIVES we may disclose information to in the event that you are unable to contact us directly for any related Audiological questions or needs pertaining to your care and/or financial issues.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to Audiology Associates, Inc.: 3615 East Joppa Road Ste 210 Parkville MD, 21234. I understand that revocation of this authorization will not affect any action the above-named entity took in reliance on those authorization before the above-named entity received my written notice of revocation.

I authorize Audiology Associates Inc. to use and disclose my protected health information as set forth above. I understand that this authorization is voluntary and that Audiology Associates Inc. cannot condition my treatment, service, etc., on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship. This authorization will expire (1) one year from the date it is signed.

Printed name of patient or personal
representative

Date of Birth

Signature of patient or personal
representative

Date Signed:



Audiology Associates, Inc. Financial and Treatment Policy Page 1

Effective 07/27/2026

Thank you for choosing us as your hearing healthcare provider. We are committed to your treatment being successful. The following is a statement of our financial and treatment policy, which we require you to read and sign prior to any evaluation or treatment. Please let us know if you have any questions regarding this policy.

COPAYMENTS are due at the time of visit. MEDICARE requires a physician's order or a signed Advanced Beneficiary Notice acknowledging patient responsibility for all audiology services. REFERRALS and PHYSICIAN ORDERS are due at the time of visit. We accept CASH, CHECKS, VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS. All REFUNDS are issued via check.

Regarding Treatment

The undersigned consents to the provision of medical care, diagnosis and/or treatment rendered by Audiology Associates Inc.

Regarding Cancellation or Missed Appointments

For all patients, if you are unable to make a scheduled appointment for any reason, we require at least 24 hours' notice to cancel your appointment. You may cancel by phone, text message, or email. If you fail to cancel your appointment with at least 24 hours' notice, or if you fail to show up to your scheduled appointment without canceling, you will be subject to a \$50 cancellation fee. Three late cancellations and/or no shows will result in your preclusion from future services with AAI. Patients will be informed upon being precluded from future services.

Regarding Insurance (PLEASE INITIAL BELOW ACKNOWLEDGING AGREEMENT)

Your insurance policy is a contract between you and your insurance company. **Please make sure that you understand your insurance policy. Please be advised that some, or all, of the services provided may not be covered under your insurance plan and may therefore be your financial responsibility. Any applicable copayments, deductibles, and coinsurance amounts required by your insurance plan along with non-covered services will be billed to you.** Please understand that insurance companies do not always have knowledge of the financial agreements patients make directly with our practice. Because of this your Explanation of Benefits (EOB) may indicate that you owe no payment or that a service is not your responsibility. However, by signing this Financial Policy, you acknowledge and agree to be financially responsible for all non-covered services in accordance with the terms of this agreement. A quote of benefits and/or Pre-authorizations does not guarantee payments or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the members' contract with their insurance at the time of service. We are participating providers with most insurance carriers. If your insurance company denies your claim, we will make reasonable effort to resolve their denial. If your insurance has not paid your claim within 60 days, you may be responsible for payment in full. If you belong to an HMO, MCO, or POS, it is your responsibility to obtain a referral from your primary care physician's office. If you are seen without a referral, payment will be due at the time of service.

Initial: _____

Continued on Next Page



Audiology Associates, Inc. Financial and Treatment Policy Continued Page 2

Usual and Customary

Our practice is committed to providing the best hearing healthcare for our patients, and we charge what is usual and customary for our area. For insurance carriers not contracted with us, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Regarding Communication – PATIENT MUST COMPLETE

I agree to allow AAI to contact me regarding my treatment and services by (check all that apply):

☐ Home Phone ☐ Cell Phone including Text Message ☐ Email

I authorize AAI to leave messages for me when I am unavailable. I understand messages and emails may contain confidential information. I assume responsibility to inform the practice of changes to my contact information or my preferences or to revoke this specific communication consent at any time.

Regarding Medical Scribe

Audiology Associate may employ an Artificial Intelligence (AI) medical scribe to complete chart notes and reports. I agree to be recorded during office visits for this purpose.

Past Due Accounts

Audiology Associates, LLC will file your claim with your insurance, if we participate with your insurance; otherwise, payment is required in full for all services at the time they are rendered. You are responsible for all charges not covered by your insurance company. All co-payments and deductibles are to be paid in full within 90 days of your first statement being generated. Unpaid balances after 90 days will incur a \$5.00 statement fee. Unpaid balances that are turned over to an external collection agency will incur a fee of 25% of the amount due on the account. You are responsible for all legal fees if your account is turned over to a lawyer for collection. Your signature below signifies your understanding and willingness to comply with this policy.

Check Return Policy

Returned check may be assessed up to a \$20.00 service charge (per resubmit to bank).

I authorize the release of information to primary/secondary insurance companies.

I understand that I am responsible for my bill (Both parent(s) and legal guardian(s) are responsible for the minor's bill).

I authorize payment directly to Audiology Associates, Inc.

I permit a copy of this authorization to be used in place of an original.

I have read pages 1 and 2 of the policy above and understand and agree to terms as list.

Signature of Responsible Party

Date

Signature of Co-Responsible Party

Date