ATHENS OCONEE AUDIOLOGY

Athens Oconee Audiology
1360 Caduceus Way
Building 200 Suite 101
Watkinsville, GA 30677
706-310-7115 (P) 706-310-7116 (F)

<table>
<tr><td colspan="2">Patient Name:</td><td colspan="2" rowspan="2">Relationship to Patient:
(_) Biologic (_) Step
(_) Adoptive (_) Grandparent
(_) Other (_) Foster</td><td>Sex:
Male Female</td></tr>
<tr><td colspan="2">Person Completing this Form:</td><td>Patient's Date of Birth:</td></tr>
<tr><td colspan="2">MAILING Address:</td><td colspan="2">City:</td><td>Patient's Age:</td></tr>
<tr><td>State:</td><td>Zip Code:</td><td colspan="3">Who Referred you to this clinic?</td></tr>
<tr><td colspan="2">Street Address, if different City, State, Zip</td><td colspan="3" rowspan="3">RACE:
(_) White
(_) American Indian
(_) Asia, India, Pakistan
(_) Black/African American
(_) More than one race
(_) Decline to report
(_)Other_____

ETHNICITY:
(_) Hispanic or Latino
(_) NOT Hispanic or Latino

Language Preference:
(_) English
Specify if not English:</td></tr>
<tr><td>Home Phone:</td><td>Cell Phone:</td></tr>
<tr><td>Work Phone:</td><td>Email Address:</td></tr>
</table>

AUTHORIZATIONS AND RELEASES

Please initial each section and sign at the bottom. If you have any questions, please do not hesitate to ask.

Treatment Authorization

_____ I authorize you to give me reasonable and proper medical care by today's standards.

Patient Contact Release

_____ I authorize Athens Oconee Audiology to leave a voicemail at the numbers below if they are unable to reach me by phone.

Home: Yes No Cell Phone: Yes No Work: Yes No

Financial Policy

_____ **By initialing here and signing below**, I acknowledge and agree to the terms of the financial policy as outlined below:

We will try to answer questions regarding health insurance coverage, but your insurance contract is between you and your insurance company. Since we are not party to that contract, we suggest that you speak to your carrier to get a clear understanding of your coverage. Our relationship is with you and not your insurance company.

We will submit claims directly to your insurance carrier. You must realize that not all services are covered by all insurance carriers. Each carrier determines what they will cover (pay for).

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We participate in some insurance plans, but not in others. If we are not participating providers in your medical insurance plan, then your medical insurance plan may pay some of the charges for care provided, but you are responsible for charges and fees not paid by the insurance carrier.

Payments for services, including co-payments, are due at the time services are rendered. We accept cash, checks, Visa, MasterCard, American Express, Discover and Care Credit. Any payment received directly to you from your insurance company for services rendered by Athens Oconee Audiology must be sent to our office immediately.

Returned checks may be subject to a fee of $25.00. Interest will be charged on delinquent accounts. Failure to settle an account balance may result in collections proceedings and a 30% collection fee will apply. Missed appointments may be subject to a $50 no show fee.

Medicare Lifetime Signature on File (if applicable)

_____ **By initialing here,** I request that payment of authorized Medicare benefits be made to Athens Oconee Audiology for any services furnished to me by a member of this group. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services any information needed to determine these benefits or benefits payable for related services.

Acknowledgement of Receipt of Notice of Privacy Practices

_____ **By initialing here,** I acknowledge that I received a copy of Athens Oconee Audiology's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

Authorization to Use and Disclose Health Information

_____ **By initialing here,** I request and authorize Athens Oconee Audiology to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

My protected health information may be used or disclosed to the following: (Please list any family members or caregivers who assist in your care. If none, put NONE.)

_____

By signing below, I assert that I have read and agree to the checked terms described above.

_____ _____
Patient/Guardian Signature Date

_____
Patient/Guardian Name

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MEDICAL HISTORY

Pediatrician:_____ Clinic: _____ Clinic Address: _____

City_____ State____ Zip _____

Does your child receive any special services (Speech therapy, occupational therapy, etc.) ☐ Yes or ☐ No
If yes, what services, when did they start, and how long:_____

_____

Is your child currently taking any medications? ☐ Yes or ☐ No
If yes, what medications, dosage, how long:_____

Is your child currently in the process/ up to date for receiving their childhood vaccinations? ☐ Yes or ☐ No

Has your child been diagnosed with any of the following:

☐ Aids/HIV	☐ Diabetes	☐ Head Injury	☐ CHARGE Syndrome
☐ Cancer	☐ Encephalitis	☐ Heart problems	☐ Cleft Lip/palate
☐ Measles	☐ Chicken Pox	☐ Cytomegalovirus (CMV)	☐ RH incompatibility
☐ Ear tags	☐ Ear Pits	☐ Jaundice	☐ Family History of hearing Loss
☐ Allergies	☐ Seizures	☐ Down Syndrome	☐ Bacterial meningitis

Has your child had a hearing test? ☐ Yes ☐ No
If yes, when?_____ Results:_____

Has your child had any ear infections? ☐ Yes ☐ No
If yes, when?_____

Have they had any tube placements? ☐ Yes ☐ No
If yes, when?_____

Does your child wear hearing devices? ☐ Yes ☐ No
If yes, what kind?_____
How old are the devices?_____

Is there any other information that we should know regarding your child's medical history or hearing history?_____

_____

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DEVELOPMENTAL/BIRTH HISTORY

Do you think your child has hearing loss? ☐ Yes ☐ No
If yes, please describe:

_____

_____

Maternal age at birth: ___ Length of pregnancy: _____ (weeks)

Child's birth weight: _____ (lbs, oz) Birth was: ☐ Induced ☐ Spontaneous ☐ Cesarean

Did your child pass their newborn hearing screening?

☐ Passed both ears ☐ Did not pass either ear
☐ Only passed the right ear ☐ Only passed the left ear

Did any of the following complications occur during or after pregnancy? Check all that apply.

☐ CMV ☐ Recreational drugs ☐ Other/Other Infection: _____
☐ Toxoplasmosis ☐ Tobacco Use ☐ Herpes
☐ COVID ☐ Syphilis ☐ Rubella

Did any of the following complications occur during or after delivery? Check all that apply.

☐ Assisted ventilation ☐ Blood transfusion
☐ Toxoplasmosis ☐ Premature
☐ Low birth weight ☐ Hyperbilirubinemia/Jaundice, Light Therapy? ☐ Yes ☐ No
☐ ECMO ☐ NICU, How long? _____
☐ Other_____