SUSSEX AUDIOLOGY SERVICES
EAR TO EAR CARE

39 Newton-Sparta Rd Suite 1C
Newton, NJ 07860-2773
(973) 383-4100

Pediatric Registration

DATE: _____

How did you hear about us? Please let us know!
_____

Referred by_____

Pediatrician _____

PLEASE PRINT AND FILL OUT ALL SECTIONS COMPLETELY!

PATIENT
LAST NAME:_____FIRST NAME:_____MI:_____

ADDRESS:_____APT#:_____City:_____State:_____ ZIP:_____

BIRTHDATE: ____/____/____ SEX: Male / Female

MARITAL STATUS: Single Married Divorced Widowed Separated

PHONE: Home:_____-_____-_____ Cell:_____-_____-_____ Okay to Text? YES / NO
Okay to Leave voicemail? YES /NO
EMAIL: _____ Okay to Email? YES / NO

Parent Responsible for Account (Last Name)_____First Name _____MI_____

(their) Employer_____ Occupation_____

Employer Address_____ Employer Phone#_____

MINOR PATIENTS: A legal guardian must accompany all minor patients, including legal guardianship documents if not parent(s).

Legal Guardian's Signature (If Applicable): _____

document type provided: _____ Date: _____

Primary Insurance Company: _____ID#_____
Policy holder's Name_____ Policy holder's DOB_____/_____/_____
Employer: _____ Employer's Phone: _____
Address IF different from above: _____
Phone # _____

Secondary Insurance Company: _____ID#_____
Policy holder's Name_____ Policy holder's DOB_____/_____/_____
Employer: _____ Employer's Phone: _____
Address IF different from above: _____
Phone # _____

ASSIGNMENT AND RELEASE

I authorize the release of medical information to process claims for medical benefits. I authorize payment of benefits to Audiology Services of NJ for services rendered. I understand that I am financially responsible for any services not covered by my insurance and accept responsibility for payment of my account for all services rendered. I further

Responsible Party's Signature | Relationship to patient | Date

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AUTHORIZE AUDIOLOGY SERVICES OF NJ TO SEND RESULTS TO MY PRIMARY CARE PHYSICIAN, THE REFERRING PHYSICIAN, OR TO THE SCHOOL IN THE CASE OF EDUCATIONAL REFERRALS.

Audiology Case History - Pediatric

Throughout this form, if the question does not apply, please write N/A.

Last Name:_____ First Name:_____ MI ____

Birth date: / / Age:

Child lives with: Both Parents____ Mother____ Father_____ Other_____

How did you hear about our practice?_____

Names and ages of other children at home: _____

_____

What prompted you to schedule an appointment? _____

Has the child ever had a hearing test before? Yes / No
If yes, when, where, and results? _____
_____

Do you have any concerns about the child's hearing? Yes / No
If yes, how long have you noticed the problem? _____

Does anyone in the family have hearing loss (immediate and extended family) that began before the age of 30? Yes / No

Does the child consistently respond to your voice? Yes / No

Does the child respond to sounds from other rooms? Yes / No

Does the child get startled by loud sounds? Yes / No

Has the child ever had surgery on their ear(s)? Yes / No If yes, when and for what?_____
_____

Does the child currently or have they ever worn hearing aids? Yes / No If yes, when was the child first fit? _____

Does the child receive preferential classroom seating? Yes / No

Pregnancy and Birth History

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Was the pregnancy and/or delivery abnormal in any way? Yes / No

Medical History

Do you have any medical concerns about the child? Yes / No

If yes, briefly explain: _____

Please list any prescriptions or over-the-counter medications the child is taking and for what reason: _____

Physical Developmental History

Do you have any concerns about the child's physical development? Yes / No

If yes, briefly explain: _____

Does the child lose their balance or fall easily? Yes / No

Speech and Language History

Do you have any concerns about the child's speech and/or language? Yes / No

Additional History

Do you have any other concerns about the child? Yes / No

If yes, briefly explain: _____

Does the child:

have attention/concentration difficulties? Yes / No

receive any special education or early intervention services? Yes / No

Do you feel that the child is having any difficulty in school? Yes / No

RESPONSIBLE PARTY'S SIGNATURE RELATIONSHIP TO PATIENT DATE

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CANCELLATION AND NO-SHOW POLICY

Our goal is to provide quality care to all our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. To be respectful of your fellow patients, please call as soon as you know you will not be able to make your appointment.

Missed Appointment Policy

When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. We know your time is valuable, and ours is too. Out of respect for our staff and our other patients, we ask that you give us at least 48 hours' notice if you need to cancel or reschedule an appointment.

- We understand that sometimes, unexpected delays can occur. The first time a client misses an appointment, we will make a note in your file.

- All future missed appointments will incur a fee, if unable to fill that time slot. The amount of the fee will be equal to 70% of the total fee for hearing evaluation and/or a $75.00 office visit fee per 30-minute appointment, whichever is more. Any cancellation or rescheduling made less than Forty-eight (48) hours will result in this cancellation fee.

- If you are more than 15 minutes late for your service, we may not be able to accommodate you. In this case, the same cancellation fee will apply as stated above. We will do our very best to reschedule your service for another time that is convenient to you.

I have read and understand the above policy and fees. If I do not sign this consent, or later revoke it, Sussex Audiology Services may decline to provide treatment to me.

RESPONSIBLE PARTY'S SIGNATURE | RELATIONSHIP TO PATIENT | DATE

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Sussex Audiology Services to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (Sussex Audiology Services' Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Sussex Audiology Services reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Sussex Audiology Services Privacy Official at **39 Newton-Sparta Rd, Suite 1C, NJ 07860-2773.**

With this consent, Sussex Audiology Services may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including hearing test results among others. Sussex Audiology Services may also send mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. **Should there be a breach in my protected health care information, Sussex Audiology Services will contact me by any and all means possible and inform me of the plan to rectify it.**

I have the right to request that Sussex Audiology Services restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Sussex Audiology Services' use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Sussex Audiology Services may decline to provide treatment to me.

Responsible Party's Signature	Relationship to Patient	Date