

**Patient Information**

Today's Date: \_\_\_\_\_

Chart Number: \_\_\_\_\_

Name: \_\_\_\_\_  
(First, Middle, & Last)

Age: \_\_\_ Gender: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone hm: \_\_\_\_\_ WK \_\_\_\_\_

Cell: \_\_\_\_\_ Carrier: \_\_\_\_\_ Email: \_\_\_\_\_

Family Dr.: \_\_\_\_\_ Referred by Dr.: \_\_\_\_\_ Referred for: \_\_\_\_\_

Responsible Party \_\_\_\_\_ DOB: \_\_\_\_\_

SSN: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**INFORMED CONSENT AGREEMENT**

I, the undersigned, understand that the evaluation of the hearing (auditory) system requires the use of specialized instrumentation. During the course of the evaluation, I understand that various earphones or acoustic probes will be placed over my ears or in my ear canals. Acoustic (sound) signals will be delivered to the ears through either of these types of earphones. Some of the sounds will be loud, but scientific evidence has shown that these loud sounds will not cause any damage to the ear or to the hearing. In the event of amplification or other custom devices, I consent to the placement of foam or cotton blocks in the external ear canals as well as materials (silicon) to make ear impressions. In the case of Balance testing and/or ABR Testing, alcohol wipes will be used to clean the area of the skin that taped electrodes will be placed. These electrodes do not deliver any type of electrical signal to you, they only measure the electrical activity normally generated by the body. Additionally, for Balance testing, water will be placed into the ear canals through a small irrigator tube to measure the strength of each ears response to the water temperature.

XX \_\_\_\_\_ Signature of Patient or Legal Guardian

**ATTENTION MEDICARE PATIENTS:**

We will file your Medicare and supplements, but Medicare will only pay for services that it determines to be 'reasonable and necessary' under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is 'not reasonable and necessary' under Medicare program standards, Medicare will deny payment for that service. I believe that, in *your* case, Medicare is likely to deny payment for a Complete Hearing Exam (CAE) , ABR, OAE, ENG (Balance) Testing or Tympanometry for the following reasons: if the diagnosis is Sensorineural Hearing Loss, if the procedure/service is not paid separately or if deemed not reasonable and necessary by Medicare.

**ALL CHARGES ARE DUE AT THE TIME OF SERVICE:**

Please be prepared to pay your account at the time of each office visit or service delivery. All accounts are due and payable at the time of each service. IF statements are sent on open accounts, the payment is due within 30 days from the date of services. If the account is referred to an attorney or collection agency, the patient or responsible party hereby agrees to pay attorney's fees and the cost of collection.

Authorization for assignment of insurance claims and release of medical records is hereby given. *I understand that I am responsible for any amount not covered, or not approved, by insurance.* For Medicare patients, I have been notified by my Audiologist that he believes, that in my case, Medicare is likely to deny payment for the services identified above, if the reasons stated above apply. *I agree to be personally and fully responsible for payment.*

XX \_\_\_\_\_ Signature of Patient or Legal Guardian