Kingston Audiology Center

211 Hurley Avenue · Kingston, NY 12401
845.331.9160 | kingstonaudiology.com

How did you hear about us? _____

PERSONAL INFORMATION

Patient's Name _____
FIRST MIDDLE LAST

Address _____

_____
CITY STATE ZIP

Telephone *(home)* _____ *(work)* _____ Employer _____

Birth Date _____ Male _____ Female _____ Marital Status _____

Full Name of Primary Care Physician _____

In case of an emergency, name and number of who we notify _____

Email Address _____ May we contact you via email? YES ____ NO ____

INSURANCE INFORMATION - PLEASE READ AND SIGN/INITIAL

DISCLAIMER: As a professional courtesy, we will submit your claim to your insurance provider, but this does not guarantee their payment. You accept responsibility for copays, deductibles, or uncovered procedures. If you have a hearing aid benefit, you may be required to pay for your hearing aid upfront.

PLEASE INITIAL: _____

PLEASE BRING YOUR INSURANCE CARD(S) WITH YOU TO BE COPIED FOR YOUR FILE.

If health insurance is ***not*** in your name, please provide the following information:

_____ _____
Name of Insured Relationship to Patient

_____ _____
Insured's Date of Birth Insured Employer

I hereby authorize Lorri Perry, Au.D., and her associates to furnish information to my insurance carrier concerning my illness and treatment, and I hereby assign to her all payments for services rendered to my dependents or myself. I understand that I am responsible for payment.

Patient or Guardian Signature _____ **Date** _____

PLEASE READ AND SIGN:

*I hereby authorize Kingston Audiology Center to release audiological records to _____

Patient or Guardian Signature _____ **Date** _____

PRIVACY PRACTICE NOTICE: According to government law, we are required to make available to you a copy of our privacy practice notice. Your signature below acknowledges your receipt of such.

Signature _____ **Date** _____

Federal law requires a medical evaluation for hearing loss by an otolaryngologist, or if none is available, by another licensed physician. You have the right to waive this requirement. If you waive this requirement, you must sign a statement of waiver of your rights.

I am aware that federal law requires a medical evaluation for hearing loss. However, I would like to waive my rights of this requirement.

Patient or Guardian Signature _____ **Date** _____

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PATIENT FINANCIAL RESPONSIBILITY DISCLOSURE STATEMENT

Your signature below forms a binding agreement between Kingston Audiology Center (KAC) and the Patient who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

ALL CHARGES FOR SERVICES RENDERED ARE DUE AND PAYABLE AT THE TIME OF SERVICE.

Medical Insurance: We have contracts with many insurance companies, and we will bill them as a service to you. As the Responsible Party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as the Responsible Party must:

- Inform KAC of the current address and phone number for the Patient and the Responsible Party.
- Present all current insurance cards prior to each office visit.
- Verify at each visit that the information is current by signing our data sheet.
- Pay any required copay at the time of the visit.
- Pay any additional amount owing within 30 days of receiving a statement from our office. (When KAC receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you).

RETURNED CHECK POLICY

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the Patient or the patient's Responsible Party will be responsible for the original check amount in addition to a $25.00 Service Charge. Once notice is received of the returned check, KAC will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance—in addition to the $25.00 check Service Charge.

NON-PAYMENT ON ACCOUNT

Should collection proceedings or other legal action become necessary to collect an overdue account, the Patient or the patient's Responsible Party understands that KAC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The Patient, or patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 18% APR, all court costs and attorney fees, and a collection fee added to the outstanding balance. By signing below, you agree to accept full financial responsibility as a Patient who is receiving medical services or as the Responsible Party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please Print) _____

Patient Signature _____ **Date** _____

Responsible Party Name (Please Print) _____

Responsible Party Signature _____ **Date** _____