Appalachian AUDIOLOGY PLLC
www.appalachianaudiology.com

130 Mabry Hood Road, Suite 103- Knoxville, TN 37922
Phone: 865-357-2334
Fax: 865-357-2416

Registration Form

Preferred Title: Dr. ____ Mr. ____ Mrs. ____ Ms. ____ Miss: ________ Marital Status: ______________________

Legal First Name: _________________________ Middle Initial: _____ Last Name: ________________________________

Date of Birth: __________________ Street Address: ____

City: _____________________________________ State: ______________ Zip Code: _________________________

How did you hear about Appalachian Audiology? ____

Referred by: ____

I authorize Appalachian Audiology to communicate with me the following ways: English ___ Spanish ___ Other ______

Yes	No	
☐	☐	Home Phone: ____
☐	☐	Cell Phone: ________________________________ Spoken ____ Text ____
☐	☐	Office Phone: ____
☐	☐	Email: ____
☐	☐	Email Newsletter (Monthly): ____
☐	☐	Family Members: Name: ____
		Name: ____

Do you plan to use your health insurance to pay for our services? ____

Medicare and many insurance companies do not pay for hearing aids. Medicare will not pay for diagnostic testing to fit or modify hearing aids. Please check with your insurance carrier to confirm if a referral is needed. If you plan to use health insurance to pay for our services, please bring all insurance cards to scheduled appointments and provide the following information:

Insurance Information

Primary Insurance: ____

Secondary Insurance: ____

Primary Cardholder: ___________________________________ Birthdate: _____________ Relationship: _______________

Acknowledgement of Receipt of Privacy Policy

Please review Appalachian Audiology's Privacy Policy by clicking here (online) or viewing the Privacy Policy below.

I have reviewed Appalachian Audiology's Privacy Policy and have no questions or concerns.

Signature: ____

(Parent/Guardian if Patient is a minor)

Date of Signature: ____

Please check one if a minor child is being evaluated:

______ Test results may be discussed with my child present.

______ I prefer test results are shared privately without my child present.

Jan Dungan, Au.D., CCC-A
Jill Barron, Au.D.

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Permission to Process Insurance

I authorize Appalachian Audiology to release information requested to process my insurance claim. I also authorize direct payment of any benefits to Appalachian Audiology, PLLC. I understand that I am responsible for the balance on my account for any professional services rendered. Appalachian Audiology will assist me with filing insurance, but I understand it is my responsibility to know the rules and regulations of my specific plan, as well as what coverage is included on my plan. It is also my responsibility to contact my insurance carrier to determine if Appalachian Audiology, PLLC is in my specific network. I have read and agree to the above and understand that it will remain in effect for one year.

Signature: ______________________________ Date: ________________

Permission to Test

I recognize that the evaluation and treatment procedures used by Appalachian Audiology clinicians are professionally and ethically acceptable and offer no probable physical or psychological risk. Although procedures are expected to be of benefit, I understand no guarantee of success can be expressed or implied.

I have read all the above information and certify that this information is correct to the best of my knowledge. I agree to the procedures scheduled and understand I may discontinue the evaluation/treatment at any time.

Signature: ______________________________ Date: ________________

Authorization for Release of Medical Information

Full Name: (Please Print) ______________________________

I authorize Appalachian Audiology, PLLC to share requested hearing healthcare information with the following family members and special friends who may inquire on my behalf:

Name: ______________________________

Name: ______________________________

Name: ______________________________

Signature: ______________________________
(Parent/Guardian if Patient is a minor)

Date of Signature: ______________________________

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Authorization for Release of Medical Records

Full Name: (Please Print) ______________________________

Date of Birth: ______________________________

I authorize Appalachian Audiology, PLLC to discuss, issue and/or request a copy of my audiogram and related hearing healthcare information/records to/from:

______ Physician: ______________________________

______ Physician: ______________________________

______ Insurance Company: ______________________________

______ Other: ______________________________

______ Other: ______________________________

Signature: ______________________________
(Parent/Guardian if Patient is a minor)

Date of Signature: ______________________________