130 Mabry Hood Rd,
NW, Suite 103 Knoxville, TN 37922
Phone: 865.357.2334
Fax: 865.357.2416
Jan Dungan, AuD, CCC-A
Andrea Plotkowski, AuD, CCC-A

Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Preferred Name:_____

First Name:_____ Middle Initial:_____ Last Name:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Date of Birth: _____/_____/_____ Gender: _____ Marital Status: **M** ☐ **S** ☐ **D** ☐ **W** ☐

Home Phone: _____ Cell Phone:_____ Voice ☐ Text ☐

Email: _____

How did you hear about Appalachian Audiology? _____

Emergency Contact: _____ Phone:_____

Relationship to patient: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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:

Primary Physician:_____

Physician:_____

Insurance Company: _____

Other:_____

Signature:_____ Today's Date: ____/____/____

By signing this form, I am authorizing the use or disclosure of protected health information as indicated above. I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices

Please Complete Reverse Page

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X_____ ACKNOWLEDGMENT OF RECEIPT OF PATIENT PRIVACY POLICY

Initial

I have reviewed the office copy of Appalachian Audiology's Privacy Policy and have no questions or concerns.
(*A printed copy is available upon request*.)

X_____ INSURANCE INFORMATION

Initial

Do you plan to use your health insurance to pay for our services? YES ☐ NO ☐

ADVANCED BENIFICIARY NOTICE: *Medicare and many insurance companies do not pay for hearing aids. Medicare will* ***not*** *pay for routine hearing evaluations or hearing evaluations to fit or modify hearing aids. It is your responsibility to check with your insurance carrier to confirm if a referral is needed. Non-covered services are patient's financial responsibility. Please bring all insurance cards to scheduled appointments and provide the following information:*

Primary Insurance:_____**Secondary** Insurance:_____

Primary Policyholder: _____ Date of Birth: ____/____/____

Relationship to Patient:_____

X_____ PERMISSION TO PROCESS INSURANCE

Initial

I authorize Appalachian Audiology, PLLC 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 file my insurance claim, but I understand it is my responsibility to know the rules and regulations of my specific policy, 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 and it's providers are in my network. I have read and agree to the above.

X_____ PERMISSION TO TEST AND TREAT

Initial

I recognize that the evaluation and treatment procedures used by Appalachian Audiology's 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:_____ Today's Date: ____/____/____

If a minor is being evaluated please check one:

☐ Test results may be discussed with my child present. ☐ I prefer results are shared privately, without my child present.