



Welcome to our audiology clinic. The following two pages will help us help you! Please fill out as completely as possible. Be sure to sign the second page. Also, please give your referral and insurance cards to the receptionist before filling this paperwork out. Let us know if you need any help.

Your Name: _____ Age: _____ Date of Birth: ____/____/____
Last First Middle Initial month day year

Street Address: _____ City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Alternate Phone: _____

Email Address: _____ Is it okay to call & leave a message, or email you? _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Responsible party & relationship to patient (if applicable): _____

Primary Physician name: _____ Physician Phone: _____

Physician Address: _____

Why are you here today? _____

How did you 'hear' of our services? _____ Do you feel you have a hearing loss? _____

Do you presently wear hearing aids? _____ Do you have ringing your ears? _____

How do you feel about your hearing in the following listening situations (circle a number for each item on list):

Listening Situation	Hearing Quality				
	Poor				Normal
1 on 1 in Quiet	1	2	3	4	5
Television	1	2	3	4	5
Music	1	2	3	4	5
Leisure Activities	1	2	3	4	5
Restaurants	1	2	3	4	5
Religious gatherings	1	2	3	4	5
Meetings/groups	1	2	3	4	5
Work Place	1	2	3	4	5
Telephone (land line)	1	2	3	4	5
Cell phone	1	2	3	4	5
Car	1	2	3	4	5
Male Voice	1	2	3	4	5
Female Voice	1	2	3	4	5
Child's voice	1	2	3	4	5



**A&A MARYLAND HEARING CENTER
CHEVY CHASE AUDIOLOGY**

www.HEARinMD.com

Ross Cushing, Au.D.
Jenifer Cushing, Au.D.

Doctors of Audiology
Fellows of American Academy of Audiology

Insurance information: Please note that most insurance companies (including Medicare require a medical referral. If you do not have a referral, ask our receptionist to call your physician to see if we can get one faxed from his/her office).

Primary Insurance

Primary Insured Name _____ Date of Birth: ____/____/____
Last First Middle Initial month day year

Street Address: _____ City: _____ State: _____ Zip Code: _____

Marital Status: _____ Employment Status: _____ Occupation: _____ Employer: _____

Insurance Company: _____ Insured ID Number: _____

Secondary Insurance

Secondary Insured Name _____ Date of Birth: ____/____/____
Last First Middle Initial month day year

Street Address: _____ City: _____ State: _____ Zip Code: _____

Marital Status: _____ Employment Status: _____ Occupation: _____ Employer: _____

Insurance Company: _____ Insured ID Number: _____

Billing Policy: Payment for services rendered is requested at time of service. We accept Visa, MasterCard, American Express, & Discover card. A service charge will be computed by periodic rate of 1.5% and will be applied to the balance of your statement for past due accounts over 30 days. It is your responsibility to know whether your insurance company covers hearing testing and related goods and services, and whether or not pre-certification or a complete Uniform Referral from my physician is required in order to have insurance billed for hearing tests. It is also your responsibility to obtain the appropriate referral from your physician and present it at the time of the appointment. You are responsible for the hearing testing at the time of testing if you do not provide the appropriate referrals. If your insurance does not pay the claim within 30 days of submission, it is your responsibility to pay A&A Maryland Hearing Center & Chevy Chase Audiology and resubmit the claim on your own.

We Care About Your Privacy

A & A Maryland Hearing Center & Chevy Chase Audiology are proud to be 100% HIPAA compliant. Our company also provides patients with the opportunity to review the Notice of Privacy Practices. Our receptionist has a copy at the front desk. Please let the receptionist know if you would like to review the notice. Our company will only disclose your hearing health information, with your permission, for reasons directly related to the purpose of your visit. We will let you know at your appointment if we need to release information to a 3rd party so that you will have the opportunity to decide whether or not you want to release the information. One service, in particular, we feel benefits our patients is a report sent to your primary care physician to keep them “in the loop” about your hearing health care.

Do we have your permission to send a report about your hearing test results to your physician? Yes No

Please sign if you have reviewed and accept our billing and privacy statements:

_____ Date _____
Signature of patient