



TAYLOR LISTENING CENTER
 ——— TLC FOR YOUR EARS ———

First Name: _____ MI: _____ Last Name: _____

Prefer to be called: _____ Date of Birth: ____/____/____

Sex: Male Female Marital Status: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Preferred to be contacted by (circle one): home work cell email

Primary Care Physician: _____ Phone Number: _____

How did you hear about us? _____ Do you smoke? Y N

Currently working? Y N Full/Part Time? FT PT Occupation: _____

Please list any medication(s) that you are currently taking.

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

****If the policy holder of your insurance is anyone but you, please provide their info here****

Primary Insurance Secondary Insurance Policy Holder Name: _____

Policy Holder Date of Birth: _____ Relationship: _____

I hereby authorize Taylor Listening Center to release any medical records necessary to process my insurance claim. I am responsible for all financial obligations of health services for the above patient and for reimbursement and payment of claims from my insurance company. I authorize payment of medical benefits directly to my medical provider.

Signature: _____ Date: _____

ALL NON-COVERED SERVICES, COPAYS AND BALANCES ARE DUE AT TIME OF VISIT.



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PATIENT HEARING SURVEY

*Please **circle** responses*

- | | | | | |
|--------------------------------------------------------------------------------------------------|--------|---------------|--------------|-------|
| 1. I have a problem hearing over the phone. | Always | Half the Time | Occasionally | Never |
| 2. I have trouble following the conversation when 2 or more people are talking at the same time. | Always | Half the Time | Occasionally | Never |
| 3. People complain that I turn the TV volume up. | Always | Half the Time | Occasionally | Never |
| 4. I have to strain to understand conversations. | Always | Half the Time | Occasionally | Never |
| 5. I have issues hearing in a noisy background such as a party or restaurant. | Always | Half the Time | Occasionally | Never |
| 6. I miss sounds like the phone or doorbell. | Always | Half the Time | Occasionally | Never |
| 7. I get confused about where sounds come from. | Always | Half the Time | Occasionally | Never |
| 8. I misunderstand some words in sentences and ask people to repeat themselves. | Always | Half the Time | Occasionally | Never |
| 9. I have more trouble understanding women and children. | Always | Half the Time | Occasionally | Never |
| 10. I have worked in noisy environments. | Always | Half the Time | Occasionally | Never |
| 11. Many people mumble when they talk. | Always | Half the Time | Occasionally | Never |
| 12. People get annoyed because I misunderstand what is being said. | Always | Half the Time | Occasionally | Never |
| 13. I make inappropriate responses because I misunderstand what others are saying. | Always | Half the Time | Occasionally | Never |
| 14. I avoid social situations because I cannot hear well and feel I'll reply inappropriately. | Always | Half the Time | Occasionally | Never |

PLEASE READ THIS DOCUMENT CAREFULLY.

1777 Reisterstown Road - Suite 118A - Baltimore, MD 21208
Office: (443) 544-7555 Fax: (443) 544-7552



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PLEASE READ THIS DOCUMENT CAREFULLY.

Our goal is to provide and maintain a good audiologist-patient relationship. We believe that advising you in advance of our office policies allows for good flow of communication. If you have any questions, please do not hesitate to ask a member of our staff. Thank you for choosing our practice.

Financial Responsibility Consent, Assignment of Benefits and other Office Policies

I hereby accept that I am financially responsible for all services rendered on my behalf by the Taylor Listening Center. For those insurances from whom the practice accepts assignment, I accept personal responsibility for all co-payments, deductibles and non-covered services, as indicated by my insurance coverage. I certify that the information I have reported with regard to my insurance coverage is correct. I authorize payment directly to the practice for services for which the Practice accepts assignment.

INSURANCE COVERAGE

I accept that it is my responsibility to understand my insurance benefit plan. It is my responsibility to know if a written referral or authorization is required to see the audiologist and what services are covered. I accept that I am responsible to provide this office with all required information regarding my health insurance coverage. **If the insurance company you designate is incorrect, you will be responsible for all unpaid balances. If our providers do not participate in your insurance plan, payment in full is expected from you at the time of your visit.** I accept that payments for any service not covered by insurance are due at the time of service.

UNINSURED PATIENTS

I accept that if I do not have current health insurance coverage, the entire payment for any services performed shall be paid at the time of service, payable by cash, credit card or check. Dishonored or Returned checks will incur a \$35.00 service fee.

NON COVERED SERVICES

Wax Removal/Ear Canal Cleanings: Most insurance companies do not reimburse for this service when performed by an Audiologist. For this reason, wax removal will have an out of pocket cost of **\$35***.

Hearing Aid Services/Parts for hearing aids purchased elsewhere: There will be a service/parts charge of between \$5* and \$250* depending on the service/parts needed for your hearing aid if it was NOT purchased at TLC. You will be told what the full cost is before we service your hearing aid or order your part.

MISSED APPOINTMENTS, SAME DAY APPOINTMENTS, WALK INS AND BEING LATE

We understand that there are times when you must miss a scheduled appointment due to emergencies or other obligations. A charge of **\$35* - \$65*** (depending on appointment length) will occur if an appointment is missed without notification, or if you are more than **15 minutes** late for an appointment without notification. If you are less than 15 minutes late rescheduling is at the discretion of the provider based on our schedule for that day. We cannot guarantee the availability of same day appointments, but we do our best to accommodate our patients. Because we know that our patient's time is valuable, patients who have an appointment will be seen in order based upon their appointment time, and before a walk-in. If a scheduled patient completes their appointment early, we are happy to bring back the next scheduled patient early, or fit a walk in patient on the schedule if needed. Please understand that if you come in early for your appointment, we may not be able to see you early. Or if you call in (same day) or walk in, our schedules may not have room for additional patients that do not have an appointment.



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COLLECTION OF OUTSTANDING BALANCES

All outstanding balances shall be due within 30 days. Unless we have agreed to other payment arrangements in writing, it is important that you pay all past due balances, in their entirety, prior to or at the time of your visit; however, balances that remain outstanding for a period of 90 days or more may be referred to a collection agency or attorneys' office at patient's expense.

RELEASE OF MEDICAL RECORDS

Medical records created by our office shall only be released pursuant to your express written authorization in accordance with HIPAA or other controlling laws (or under other circumstances as required by law). As a courtesy the first copy will be free of charge. In accordance with Maryland law, for all additional copies the charge will be \$15*.

ATTENTION MEDICARE PATIENTS:

As of February 7, 2018 any patient who has Medicare and is scheduled to receive a hearing test is responsible for obtaining an order/prescription from their primary care physician for a hearing test. We are required by Medicare to have this on file. The patient can bring it in on the day of the appointment or it can be faxed to the Taylor Listening Center at 443-544-7552. If the patient's physician has any questions in regards to this they can call the office at 443-544-7555. If the referral is not obtained the patient may either pay out of pocket for their hearing test, or they can reschedule their appointment. If the patient chooses to reschedule on the day of the appointment they will be responsible for a \$35* fee for cancellation of the office visit. If the patient chooses to reschedule 24 or more hours before the appointment, there is no fee.

Refusal to sign this form may result in our practice not being able to provide services to you, and could result in cancellation of your appointment. If you have any concerns about signing this form, please request to speak directly with our office manager.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Check one

- I would like a copy of Taylor Listening Center's Privacy Practice Notice
- I would not like a copy of Taylor Listening Center's Privacy Practice Notice.

By signing below, patient or responsible party acknowledges that he or she has read and understood the foregoing financial and office policies and agrees to be bound by the terms and conditions set forth therein. I also acknowledge that it was my decision to receive a copy or not receive a copy of the Privacy Practice Notice.

Patient/Guardian Signature

Date



TAYLOR LISTENING CENTER

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Our office is conveniently located in the Commerce Center at:

1777 Reisterstown Road

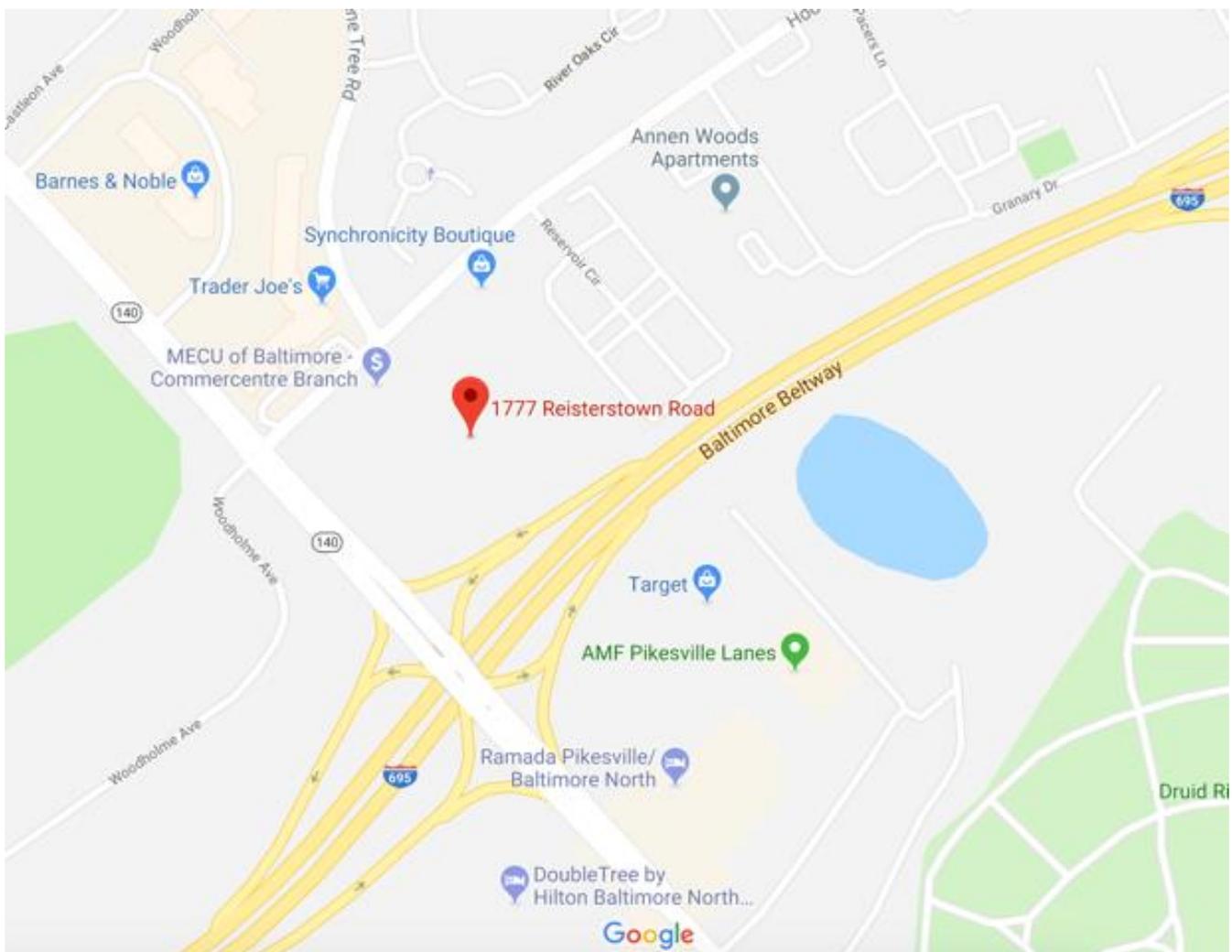
Suite 118A

Baltimore, MD 21208

Office Phone: 443-544-7555

Fax: 443-544-7552

We are located off of 695 in the Commerce Center near Ruth's Chris Steak House. We are directly next to Milk and Honey Bistro in the **WEST** Building. Take exit 20 towards Garrison, make a right at the first light (Hooks Lane) and then make a right at the next light into the Commerce Centre parking lot.



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