BRC
FAMILY HEARING
SOLUTIONS

Doctors of Audiology
Rebecca A. Price, Au.D., F-AAA
Libby Mehle, Au.D., F-AAA
Klyne Waninger, Au.D., CCC-A, F-AAA

REGISTRATION *(Minor/Dependent)*

PATIENT INFORMATION

Name _____ SSN _____
Last First Initial

Sex ☐ M ☐ F Age _____ Birthdate _____ Home Phone _____ Cellphone _____

Address _____ City _____ State _____ Zip _____

Who has legal custody (Name & Relationship)? _____

Who has consent for medical care in an emergency if we are unable to reach you (Name, Relationship, Address & Phone)?

_____

Primary Care Physician's Name _____

Whom may we thank for referring you? _____

How did you hear about us? _____

PAYMENT POLICY

PLEASE NOTE: All copay, coinsurance, non-covered charges and unmet deductible amounts are DUE AND PAYABLE AT THE TIME OF SERVICE.

SELF PAY: Payment is expected at the time of service. Please notify the receptionist of payment method. We accept cash, checks and all major credit cards.

MOTHER'S Name
Street Address _____
Mailing Address _____
City, St., Zip _____
Home Phone _____
Cellphone _____
SSN _____ Birthdate _____
Employer Name _____
Address _____
City, St., Zip _____
Phone _____ Occupation _____

FATHER'S Name
Street Address _____
Mailing Address _____
City, St., Zip _____
Home Phone _____
Cellphone _____
SSN _____ Birthdate _____
Employer Name _____
Address _____
City, St., Zip _____
Phone _____ Occupation _____

NON-CUSTODIAL PARENT(S) *(if applicable)*
Street Address _____
Mailing Address _____
City, St., Zip _____
Home Phone _____
Cellphone _____
SSN _____ Birthdate _____
Employer Name _____
Address _____
City, St., Zip _____
Phone _____ Occupation _____

PRIMARY INSURANCE (Billed 1st)
Insurance Co. Name _____
Address _____
City, St., Zip _____
Phone _____
Member's Name _____
Address _____
City, St., Zip _____
Phone _____
SSN _____ Birthdate _____
Relationship to Patient _____
Group# _____ ID# _____
Employer Name _____
Address _____
Phone _____
City, St., Zip _____

SECONDARY INSURANCE (Billed 2nd)
Insurance Co. Name _____
Address _____
City, St., Zip _____
Phone _____
Member's Name _____
Address _____
City, St., Zip _____
Phone _____
SSN _____ Birthdate _____
Relationship to Patient _____
Group# _____ ID# _____
Employer Name _____
Address _____
Phone _____
City, St., Zip _____

CONFIDENTIAL COMMUNICATIONS

You have the right to request that you receive communications regarding your protected health information in a manner and location of your choosing. Please complete the information below to assist us in meeting your needs. I wish to be contacted in the following manner (check all that apply):

- Home Telephone _____
    - OK to leave detailed message
    - Leave message with callback number only
- Work Telephone _____
    - OK to leave detailed message
    - Leave message with callback number only
- Cell Phone _____
    - OK to leave detailed message
    - Leave message with callback number only
- Written Communication
    - OK to mail to my home address
    - OK to mail to my work address
- Email _____
- Fax _____
- Other _____

CONSENT

By signing this form, I authorize the practitioners at BRC Family Hearing Solutions to provide audiological care and other such services as they may deem necessary. I understand that there are no express or implied guarantees regarding the results of any audiological testing or treatment provided at this clinic.

By signing this form, I acknowledge that I have read and understand the *Notice of Privacy Practices* given to me at the time of initial registration, which provides detailed information about my rights and how and under what circumstances my protected health information may be used and disclosed. I understand that my health information may be used and disclosed in accordance with the *Notice of Privacy Practices* so that any treatment or services I receive at this clinic may be billed to and payment collected from me, an insurance company or other third-party.

I acknowledge that BRC Family Hearing Solutions charges a No-Show/No-Call fee of $25 for all appointments that are not canceled within 24 hours of the scheduled appointment time. If the appointment is rescheduled within 30 days of the missed appointment, this fee may be waived.

I understand that I am financially responsible for payment in full for services rendered whether or not paid by insurance. I understand that charges not paid at 120 days will start to accrue an interest rate of 18% A.P.R., and charges after 150 days will be considered for further collection action. Furthermore, by signing this form, I agree to directly assign to BRC Family Hearing Solutions all insurance benefits, if any, otherwise payable to me for services rendered. I certify that the information I provided on this form is complete and accurate.

_____ _____

SIGNATURE DATE

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PEDIATRIC CASE HISTORY FORM

Patient Name _____ DOB _____ Today's Date _____

Parent(s) Name: Mother _____ Father _____

1. What is your concern today? _____
2. How did you hear about BRC Family Hearing Solutions? _____
   Referral Source _____
3. Length of pregnancy _____ weeks Birth weight _____ lbs. _____ oz.
4. Hospital of delivery _____
5. Type of delivery _____ Was labor induced? ☐ Yes ☐ No
6. Did your child spend any time in the NICU? ☐ Yes ☐ No If yes, how long? _____
7. Any complications during pregnancy or delivery? ☐ Yes ☐ No If so, please explain: _____
8. Was there a history of drug use or STD during pregnancy? ☐ Yes ☐ No If yes, please explain _____
9. Did your child pass the newborn hearing screening? ☐ Yes ☐ No If no, what ear? ☐ Right ☐ Left ☐ Both
10. Are there any concerns about your child's hearing? ☐ Yes ☐ No If yes, please explain _____
11. Is there any family history of hearing loss occurring before the age of 30 years? ☐ Yes ☐ No Relationship _____
12. Does your child currently wear hearing aids or use an auditory trainer? ☐ Yes ☐ No
13. Do you have any concerns about your child's speech and language? ☐ Yes ☐ No If yes, please explain _____
14. Is your child currently receiving speech therapy? ☐ Yes ☐ No
15. Do you have any medical concerns about your child? ☐ Yes ☐ No Explain _____
16. Please check if your child has had any of the following:

☐ Ear infections	☐ Meningitis	☐ Seizures	☐ Ear surgery	☐ Measles
☐ Kidney problems	☐ Hospitalization	☐ Mumps	☐ Vision problems	☐ Head trauma/injury
☐ Chicken pox	☐ Allergies	☐ Asthma	☐ Noise exposure (e.g., farm equipment, loud music)	

17. Is your child on any medications? Please list _____
18. Do you have any other concerns about your child? ☐ Yes ☐ No
    Explain _____
19. Does your child?
    a. Play/interact well with other children? ☐ Yes ☐ No
    b. Have attention/concentration difficulties? ☐ Yes ☐ No
    c. Receive any special education services? ☐ Yes ☐ No
    d. Have difficulty in school? ☐ Yes ☐ No

Name of school _____ Grade _____ Teacher _____

Parent or Guardian's Signature Relationship Date

2180 W. Teton Blvd., Green River, WY 82935
P: 307-875-1460 | F: 307-875-1586

brchearing@gmail.com

150 Chase Dr., Lander, WY 82520
P: 307-875-1460 | F: 307-875-1586