Allegany Hearing & Balance, LLC

938 National Hwy ● LaVale, MD 21502
Phone: 301-729-1635 ● Fax: 301-729-1697

888 Memorial Dr. Lower Level ● Oakland, MD 21550
Phone: 301-334-1018 ● Fax: 301-533-9100

Patient Data

Name: _____ **Date:** _____/_____/_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

SSN: _____ **DOB:** _____/_____/_____ **Sex:** □ Male □ Female

Marital Status: □ Single □ Married □Widowed □Separated □ Divorced

Employment Status: □ Full-Time □Part-Time □ Retired □ Unemployed **Occupation:** _____

Primary Physician: _____ **Referring Physician:** _____

E-Mail Address: _____

Emergency Contact: _____ **Phone Number:** _____

Primary Insurance Information *(If patient is also the insured, enter "SAME" for name & address)*

Insured's Name: _____ **DOB:** _____/_____/_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Patient Relation to Insured: _____ **Other Insurance:** □ Yes □ No

Insurance cards must be presented at time of appointment.

Responsibility Agreement: Copayment or payment in full is expected on the date service is rendered. Payment of fee for service is your responsibility. Our office will assist you with insurance when applicable. Maryland Medical Assistance does not cover our services if you are 21 years of age or older. We do not participate with WV or PA Medical Assistance. Please ask our receptionist about our policies for Medical Assistance.

A finance charge of 1.5 % per month is placed on all accounts after 30 days from the date of service, or 30 days for date insurance payment is received.

I have read and understand the above statements and agree to the conditions set forth. I accept financial responsibility for the fee for service. I certify the above information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

I authorize any holder of medical or other information about me to release any information needed to process this or other claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Signed: _____ **Date:** _____/_____/_____