Audiology Providers, P.C.

Hearing Health Profile

Patient Name:_____ Age: _____ Date: _____

1. Approximate date of last hearing test: _____
2. Chief complaint: ❒Hearing Loss?: ❒Right ear / ❒Left ear ❒ Tinnitus/Ringing?

   ❒Dizziness? ❒Difficulty hearing?: ❒In Quiet/ ❒In Noise ❒Telephone
3. How long have you noticed this difficulty? _____
4. Primary reason for visit: _____
5. How important is it for you to improve how you hear, understand, or communicate with others RIGHT NOW (mark on the line)

   

   0 (Not at all important) (Extremely important) **10**
6. Have you ever worn a hearing aid? (Circle) Yes or No
7. Do you wear hearing aids now? (Circle) Yes or No If so, what brand/style?

   _____ Right ear / Left ear / Both ears
8. Is this problem due to a work-related injury/exposure? ❒Yes ❒No

   If so: Date of Injury: _____ Explain: _____
9. Do you feel your hearing is changing? ☐Yes ☐No (☐Gradual ☐Sudden)
10. Any drainage from the ear within the past 90 days? Yes_____ No _____
11. Do you have any noise or ringing in your ears? Yes _____ No _____ left/right/both (circle one)
12. Have you ever been exposed to loud noise, either recently or in the past? ☐Yes ☐No
    If so, please mark all that apply: ☐Farm Machinery ☐Music ☐Hunting/Shooting ☐Military

    ☐Factory Noise ☐Power Tools ☐Jet Engines ☐Other: _____
13. Have you ever had any ear surgery? ☐Yes ☐No
14. Is there a history of hearing loss in your family? ❒Yes ❒No If so, who? _____

15. Do you have a history of chronic ear infections? ❒Yes ❒No (If yes, ❒as a child ❒as an adult)

16. How much: nicotine_____, alcohol _____ (# drinks per day/wk), caffeine_____, aspirin _____ used?

17. Have you experienced chronic or acute dizziness, light-headedness, balance problems, falls, or vertigo?

❒Yes ❒No If yes, please describe: _____

18. Do you take any prescription medications on a regular basis? Please list:

Medication: _____ For: _____
Medication: _____ For: _____
Medication: _____ For: _____
Medication: _____ For: _____
Medication: _____ For: _____
Medication: _____ For: _____
Vitamins: _____

19. Please check any of the following that you currently have or have had in the past:

❒Arthritis ❒Heart Trouble ❒Measles ❒Parkinson's ❒Asthma ❒Hepatitis
❒Meningitis ❒Bell's Palsy ❒High Blood Pressure ❒Sinusitis ❒Diabetes
❒HIV ❒Neurological Symptoms ❒Stroke/TIA ❒Head Injury ❒Visual Trouble –Loss/Sight

20. How confident are you in your own ability to use and take care of hearing aids if they are recommended? (mark on the line)

0 (Not at all confident) (Extremely confident) **10**

21. In what situations would you most like hearing aids to help you (if recommended)?:

Conversations with family or friends _____ TV _____ Telephone _____ In the car _____

Places of worship _____ Music _____ Other: _____

22. Select all that apply:

____I am not ready for hearing aids at this time.
____I have been thinking that I might need hearing aids.
____I have started to seek information about hearing aids.
____I am ready to wear hearing aids if they are recommended.
____I currently wear hearing aids, but may need new ones or not ready for new ones.

Consent To Test

I hereby consent to testing by the audiologist(s) and/or licensed hearing aid dispensers of Audiology Providers, P.C. or Hearing Aids PLUS, P.C.. This consent includes consent to take a medical history and perform diagnostic and/or audiologic testing.

_____ _____

Patient/Guarantor/Parent Signature Date

Audiology Providers, P.C.

Patient Intake Form

Name: _____ Date of Birth: ____/___/_____ Age: ____
First MI Last

Social Security # _____

Address: _____
Street Apt# City State Zip

Telephone#_____ Mobile# _____ Email_____

Occupation: _____ Employer: _____
Co. Name Address

Spouse Name: _____ Spouse Telephone # _____
Spouse Employer: _____ Spouse Date of Birth:____/___/____ Age: _____
Spouse's Social Security # _____ (only needed if spouse is insurance policy holder/or secondary)

Policy Holder: _____

Primary Insurance Co. _____ ID# _____ Grp # _____

Secondary Insurance Co. _____ ID# _____ Grp # _____

In case of emergency, contact: _____
Name Relationship Phone

Primary Care Physician: _____
Name City Phone

Would you like a copy of your test results forwarded to your physician? ❒Yes ❒No *(If so, please sign below)

How did you hear about us? (friend, family, drive by, marketing piece, newspaper)_____
If applicable, please provide the name of the person who referred you to our office: _____

In order for us to file your insurance claim for you, the following MUST be signed:

I authorize the release of any medical and/or other information necessary to process my medical claim. I also request that payment of government benefits, either to myself or to the party who accepts assignment.

Further, I authorize payment of medical benefits to be made directly to Audiology Providers, P.C. or Hearing Aids PLUS, P.C. for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

_____ _____/____/_____
Patient /Parent/Guardian Signature Date

Patient Intake Form Page 2

Medicare Patients Certification (Medicare Only)

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Act or its intermediaries or carries any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

_____ _____/____/_____

Patient /Parent/Guardian Signature Date

Responsibility of Non-Covered Services

I have been informed that the services provided to me while I am a patient of Audiology providers, P.C. or Hearing Aids PLUS, P.C. are furnished only at my direction or at the direction of my hearing health care professional and that Audiology Providers, P.C. or Hearing Aids PLUS, P.C. makes no representations concerning the medical necessity or reasonableness of such procedures or services. The decision as to the necessity or reasonableness of any procedure or service is made by the appropriate state medical program, insurance company, or its health insurance agent. I understand that I am responsible for payment for any procedure, service, or product which were provided to me at my request by my hearing health care professional and which are determined not to be reasonable and medically necessary as required by the appropriate government, or insurance medical program.

The undersigned patient recognizes that (he/she) remains financially responsible to Audiology Providers, P.C. and/or Hearing Aids PLUS, P.C. for charges not paid or covered by said insurers. Each of the undersigned insureds also hereby authorize any overpayment to Audiology Providers, P.C. and/or Hearing Aids PLUS, P.C. regarding this visit which would otherwise be payable to said undersigned to be applied and credited against any previous balance due Audiology Providers, P.C. or Hearing Aids PLUS, P.C. for which said undersigned is the responsible party.

I irrevocably assign to Audiology Providers, P.C. or Hearing Aids PLUS, P.C. all rights, title, and interest in benefits payable out of any third party action against any other person, entity, or insurance company, or out of recovery under the uninsured motorist provisions or the medical payment provision of any insurance policy (ies) or any other insurance policy (ies) under which I may be entitled.

I the undersigned guarantor, hereby guarantee full and prompt payment to Audiology Providers, P.C. or Hearing Aids PLUS, P.C. of all charges made as a result of services rendered the above named patient during this visit. I agree to pay for said charges upon the failure of said patient, any responsible insurer or any other person or firm to pay same when due. The patient is responsible for any legal or court costs required in the collection of any unpaid accounts.

_____ _____/____/_____

Patient /Parent/Guardian Signature Date

Audiology Providers, P.C.
Hearing Aids PLUS, P.C.

PRIVACY NOTICE

We understand that medical information about you and your health is personal. We are committed to protecting the confidentiality of your medical information. As part of our routine operations, we create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements.

Federal law requires us to 1) make sure that medical information that identifies you is kept private; 2) give you this notice of our legal duties and privacy practices; and 3) follow the terms of the notice that is currently in effect.

If the practices described in this notice meet your expectation, there is nothing you need to do. If you have any questions regarding this Privacy Notice, please contact our Privacy Officer, Jamie Sargent at 214.705.9994.

All employees of our company follow the terms of this notice. Some employees may share medical information with each other for purposes of treatment, payment or healthcare operations as described in this notice.

How We May Use and Disclose Medical Information About You

- **For Treatment** – We may use medical information about you to provide you with products or services. We may disclose medical information about you to other employees in order to coordinate the different products and services we offer. We may also disclose medical information about you to people outside the facility who may be involved in your medical care, such as family members or others we use to provide services that are part of your care.
- **For Payment** – We may use and disclose medical information about you so that your treatment, products, and services you received from us may be billed to and payment may be collected from you, an insurance company, or third party. For example, we may need to give your insurance company information about your hearing aids in order for claims to be filed for payment to our company or reimbursement to you. We may also tell your health care plan about treatment or products you are going to receive to obtain prior approval or to determine coverage.
- **For Healthcare Operations** – We may use and disclose medical information about you for our facility operations. These uses and disclosures are necessary to run the facility and make sure that all of our patients receive quality care. For example, we may use medical information from a number of patients to review our products and services to see if we need to make changes, or evaluate staff performance.
- **Appointment Reminders** – We may use and disclose medical information to contact you as a reminder that you have an appointment at our facility.
- **Treatment Alternatives** – We may use and disclose medical information to tell you about or recommend products or services that may be of interest to you.
- **Health-Related Benefits and Services** - We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.
- **Individuals Involved in Your Care or Payment for Your Care** – We release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care.

- **As Required by Law** – We will disclose medical information about you when required to do so by federal, state, or local law. We may also release medical information if asked to do so by law enforcement officials, such as in response to a court order or subpoena.
- **Health Oversight Activities** – We may disclose medical information to a health oversight agency for activities authorized by law. For example, we may disclose information to the Texas Department of Health relating to an audit or for licensure.

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information about you. To exercise any of these rights, you must submit the request in writing to: Audiology Providers, P.C., Attn: HIPAA Contact, 7589 Preston Rd, Ste 300, Frisco, TX, 75034

- **Right to Inspect and Copy –** You have the right to inspect and obtain a copy of medical information that may be used to make decisions about your care. If you request a copy of the information, we may charge a fee of $10.00 for the costs of copying, mailing, and administration. We may deny your request to inspect and copy in certain very limited circumstances.
- **Right to Amend –** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. As part of your written request to amend, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend information that: was not created by us, is not part of the medical information kept by our facility, is not part of the information which you would be permitted to inspect or copy, or if you ask us to amend information that is accurate and complete.
- **Right to an Accounting of Disclosures –** This is a list of the disclosures we made of medical information about you. Your request must state a time period and may not include dates before February 26, 2003. The first list you request in a 12 month period will be free. For additional list, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.
- **Right to Request Restrictions –** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care, like a family member, or a friend. Written requests for restrictions must tells us 1) what information you want to limit; 2) whether you want to limit our use, disclosure or both; and 3) to whom you want the limits to apply. **We are not required to agree to your request.**
- **Right to Request Confidential Communications –** You have the right to request that we communicate with you about medical matters in a certain way or at certain locations, such as to contact you at home, and not at work. Written requests for confidential communications must specify how or where you wish to be contacted. We will not ask you the reason for your request. We will accommodate all reasonable requests.

Changes to this Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have as well as any information we receive in the future. We will post a current copy of this notice in the facility.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Audiology Providers, P.C., or with the Secretary of the Department of Health and Human Services. To file a complaint with our company, submit your written complaint to: Audiology Providers, P.C., Attn: HIPAA Contact, 7589 Preston Rd, Ste 300, Frisco, TX, 75034.

Acknowledgement

We may ask to acknowledge receipt of this Privacy Notice. Should you decline to acknowledge receipt off this notice, we may record in your medical records the date the notice was given to you.

Signed _____ Date _____

Audiology Providers, P.C.

Patient Dizziness History

Today's Date: _____

Full Name: _____ Date of Birth: _____

Have you had any recent changes in health? Surgeries? Hospitalizations? If yes, please explain

_____
_____
_____

When was the first time you experienced the dizziness?

_____
_____

What types of things seem to bring on the dizziness or make it worse?

_____
_____

When was the last time you experienced dizziness?

_____

What caused your last episode of dizziness? (Was there a movement, an action, or activity?)

_____

Currently my dizziness……

_____ is constant
_____is always there, but changes in intensity
_____comes in episodes

If your dizziness comes and goes, how long does it last? (seconds, minutes, hours, days) _____

If your dizziness comes and goes, how often does your dizziness occur?

_____

My dizziness mostly consists of…… (Check all that apply)

_____ episodes of spinning with nausea
_____off-balance sensation
_____a light-headed or near fainting sensation
_____other – Please explain_____

Between episodes of dizziness I feel ….. (Check One)

_____normal
_____dizzy or off balance all of the time
_____other – please explain_____

My episodes of dizziness occur……(Check all that apply)

_____spontaneously – Nothing I do seems to bring the dizziness on or turn it off
_____only when standing or walking
_____only with head motion
_____only with specific head and body positions - please describe

_____
_____

When I roll over in bed ….. (Check One)

_____nothing unusual happens
_____the room seems to spin sometimes

What types of things, if any, help your dizziness go away? (sitting, laying down, closing eyes, etc.)

_____
_____

I have difficulty hearing? Yes No **If yes……..** Right Left Both

My hearing difficulties are in ……. My right ear My left ear In both ears

I have ringing or other sounds in … My right ear My left ear In both ears

I have a sensation of fullness in …... My right ear My left ear In both ears

I have had ear surgery in …….. My right ear My left ear In both ears

Please respond yes or no for the following questions.

Did you have a cold, flu, or other virus prior to the onset of your dizziness? _____
Did you have a persistent cough prior to the onset of your dizziness? _____
Did you lift something heavy, sneeze violently, fly in an airplane, go scuba diving or snorkeling prior to the onset of your dizziness? _____
Have you ever suffered head or neck trauma? If yes when _____
Were you exposed to any irritating fumes, or chemicals prior to the onset of your dizziness? _____
Do you get dizzy if you have not eaten for long periods of time? _____

For ladies, is your dizziness connected with your menstrual period or other hormonal changes?

_____

Have you recently received new glasses? _____

Have you had any recent changes in your vision?_____

When was the last time you had your vision checked? _____

Do your visual changes occur with the onset of your dizziness? _____

Do you have high blood pressure? If yes, do you take medication for this condition _____

Do you consider yourself to be an anxious or tense person? _____

Do you have a history of migraine headaches? If yes, do you take medication for that condition?

_____

In the last year I have experience the following……. (please check all that apply)

Loss of consciousness _____

Occasional loss of vision _____

Seizures or convulsions _____

Slurring of speech _____

Difficulty swallowing _____

Heart palpitations _____

Weakness in one hand, arm, or leg _____

Tingling around the mouth _____

Double vision _____

Tendancy to fall _____

Spots before the eyes _____

Loss of balance when walking _____

I have been diagnosed with….. (Check all that apply)

Diabetes _____

Stroke _____

High Blood Pressure _____

Migraine Headaches _____

Arthritis _____

A neck or back injury _____

Irregular Heartbeat _____

Allergies _____

Please check below for any medications you have used for dizziness or are currently taking.

Antivert (Meclizine) _____

Valium (Diazepam) _____

Dyazide (Diuretic) _____

If you take any of the medications listed above, how long have you taken them, and do they help?

_____

_____

Please list all medications that you currently take, prescription, herbal, or over the counter.

_____

_____

_____

_____

Have you ever been previously evaluated for dizziness? If yes, where and when?

_____

_____

Audiology Providers, P.C.

Dizziness Handicap Inventory

1. (P)Does looking up increase the problem? Yes No Sometimes
2. (E)Because of your problem do you feel frustrated? Yes No Sometimes
3. (F)Because of your problem do you restrict your travel for business or for recreation? Yes No Sometimes
4. (P)Does walking down the aisle of a supermarket increase your problem? Yes No Sometimes
5. (F)Because of your problem do you have difficulty getting into or out of bed? Yes No Sometimes
6. (F)Does your problem significantly restrict your participation in social activities such as going out to dinner, movies, dancing, or parties? Yes No Sometimes
7. (F)Because of your problem do you have difficulty reading? Yes No Sometimes
8. (P)Does performing more ambitious activities like sports, dancing, and household chores such as sweeping or putting dishes away increase your problem? Yes No Sometimes
9. (E)Because of your problem are you afraid to leave your home without having someone accompany you? Yes No Sometimes
10. (E)Because of your problem have you been embarrassed in front of others? Yes No Sometimes
11. (P)Do quick movements of your head increase your problem? Yes No Sometimes
12. (F)Because of your problem do you avoid heights? Yes No Sometimes
13. (P)Does turning over in bed increase your problem? Yes No Sometimes
14. (F)Because of your problem is it difficult for you to do strenuous housework or yardwork? Yes No Sometimes
15. (E)Because of your problem are you afraid people may

think you are intoxicated? Yes No Sometimes

16. (F)Because of your problem is it difficult for you to go for a walk by yourself? Yes No Sometimes

17. (P)Does walking down a sidewalk increase your problem? Yes No Sometimes

18. (E)Because of your problem is it difficult for you to concentrate? Yes No Sometimes

19. (F)Because of your problem is it difficult for you to walk walk around your house in the dark? Yes No Sometimes

20. (E)Because of your problem are you afraid to stay home alone? Yes No Sometimes

21. (E)Because of your problem do you feel handicapped? Yes No Sometimes

22. (E)Has your problem placed stress on your relationships with members of your family or friends? Yes No Sometimes

23. (E)Because of your problem are you depressed? Yes No Sometimes

24. (F)Does your problem interfere with your job or household responsibilities? Yes No Sometimes

25. (P)Does bending over increase your problem? Yes No Sometimes

P- physical subscale items
E-emotional subscale items
F-functional subscale items

Scoring
Yes – four points
No - two points
No – zero points

Patient Intake Form Page 2

Medicare Patients Certification (Medicare Only)

I request payment of authorized Medicare benefits to be made to Audiology Providers, P.C. for any services rendered. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents and information needed to determine these benefits or related services to pay the claim. If there are any other insurance carriers, my signature authorizes releasing of information. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible for only the deductible, coinsurance, and the non-covered services. Coinsurance and the deductible are based upon the charge determined by the Medicare carrier.

_____ _____/____/_____

Patient /Parent/Guardian Signature Date

Responsibility of Non-Covered Services

I have been informed that the services provided to me while I am a patient of Audiology providers, P.C. or Hearing Aids PLUS, P.C. are furnished only at my direction or at the direction of my hearing health care professional and that Audiology Providers, P.C. or Hearing Aids PLUS, P.C. makes no representations concerning the medical necessity or reasonableness of such procedures or services. The decision as to the necessity or reasonableness of any procedure or service is made by the appropriate state medical program, insurance company, or its health insurance agent. I understand that I am responsible for payment for any procedure, service, or product which were provided to me at my request by my hearing health care professional and which are determined not to be reasonable and medically necessary as required by the appropriate government, or insurance medical program.

The undersigned patient recognizes that (he/she) remains financially responsible to Audiology Providers, P.C. and/or Hearing Aids PLUS, P.C. for charges not paid or covered by said insurers. Each of the undersigned insureds also hereby authorize any overpayment to Audiology Providers, P.C. and/or Hearing Aids PLUS, P.C. regarding this visit which would otherwise be payable to said undersigned to be applied and credited against any previous balance due Audiology Providers, P.C. or Hearing Aids PLUS, P.C. for which said undersigned is the responsible party.

I irrevocably assign to Audiology Providers, P.C. or Hearing Aids PLUS, P.C. all rights, title, and interest in benefits payable out of any third party action against any other person, entity, or insurance company, or out of recovery under the uninsured motorist provisions or the medical payment provision of any insurance policy (ies) or any other insurance policy (ies) under which I may be entitled.

I the undersigned guarantor, hereby guarantee full and prompt payment to Audiology Providers, P.C. or Hearing Aids PLUS, P.C. of all charges made as a result of services rendered the above named patient during this visit. I agree to pay for said charges upon the failure of said patient, any responsible insurer or any other person or firm to pay same when due. The patient is responsible for any legal or court costs required in the collection of any unpaid accounts.

_____ _____/____/_____

Patient /Parent/Guardian Signature Date

All Patients Please Read and Sign

Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims or accept responsibility for negotiating claims with your insurance company. As a courtesy, we will be happy to help you determine the coverage you have available.

I hereby assign all medical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to Audiology Providers, P.C. and/or Hearing Aids PLUS, P.C. A photocopy of my insurance card and a copy of my driver's license are to be considered as valid and original.

I am financially responsible for all charges whether or not paid by my insurance company.

I hereby authorize Audiology Providers, P.C., and/or Hearing Aids PLUS, P.C. to release all information necessary to secure the payment. If insurance pays only a portion of the bill or fails to make payment to Audiology Providers, P.C. and/or Hearing Aids PLUS, P.C. within 90 days, I will be responsible for payment of balance in full at that time.

_____ _____/____/_____

Patient /Parent/Guardian Signature Date