Hearing Health Profile

Audiology Providers P.C.

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? (WE NEED **ALL** INFORMATION COMPLETED)

Medication: _____ Route Taken: _____ Dosage/Frequency: _____
Medication: _____ Route Taken: _____ Dosage/Frequency: _____
Medication: _____ Route Taken: _____ Dosage/Frequency: _____
Medication: _____ Route Taken: _____ Dosage/Frequency: _____
Medication: _____ Route Taken: _____ Dosage/Frequency: _____
Medication: _____ Route Taken: _____ Dosage/Frequency: _____
Medication: _____ Route Taken: _____ Dosage/Frequency: _____
Medication: _____ Route Taken: _____ Dosage/Frequency: _____
Vitamins: _____ Route Taken: _____ Dosage/Frequency: _____

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.

I hereby consent to testing by the audiologist(s) of Audiology Providers, P.C. or Hearing Aids PLUS, P.C.. This consent also includes consent to take a medical history, perform diagnostic and/or audiologic testing, and when applicable: remove cerumen, and/or make ear impressions.

_____ _____
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

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

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 tell 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 of this notice, we may record in your medical records the date the notice was given to you.

Signed _____ Date _____

Medical History Relating to Hearing Loss

1. Chief complaint relating to hearing difficulty:

2. Situation that causes the greatest difficulty in terms of hearing loss:

3. Pertinent service history relating to hearing loss/difficulty. Brief history of how the condition occurred:

4. When did you begin having hearing loss symptoms:

5. What are your current hearing loss symptoms:

6. History of Military occupational and recreational noise exposure:

   Military:
   Recreational:
   Occupational:

7. Branch of Military: Years in Military: Job/Duty in Military:

TINNITUS

1. Is there a current complaint of tinnitus/ringing in the ears present? YES / NO

   If YES
   Date and circumstance when Tinnitus first presented: (please provide details)

   Is Tinnitus constant or recurrent (intermittent)?

   The tinnitus is present in which ear(s):

2. If there is a complaint for tinnitus but **you are not currently experiencing tinnitus:**
   When did you last experience tinnitus?

   Describe the tinnitus experienced at that time:

   How frequently in a year do you experience tinnitus?

Please describe in your own words the effects of your hearing loss on daily activities and on occupational functioning:

Please describe in your own words the effects of your tinnitus on daily activities and on occupational functioning: (if applicable)