Patient Information sheet 2015

Date:_____

Patients
Name:_____

LAST FIRST MIDDLE INITIAL

Street Address:_____

City:_____ State:_____ Zipcode:_____

Cell No._____ Home No._____ Work No._____

Date of Birth:_____ Age:_____ Sex:_____ Married/Single:_____

May we email you? ___**Email Address**:_____

How did you hear about us (REFERRAL SOURCE)?_____

Primary Care:_____ Patient's social Security No._____

Patient's Employer:_____ Phone No._____

Spouse's Name:_____ Phone No._____

In case of emergency contact:_____ phone No:_____

Primary Insurance Company Name:_____

Secondary Insurance Company Name:_____

Medical Hearing History

Date:_____

Name:_____

1. What is your reason for this visit?_____

2. Do you have family with history of Hearing Loss? Y / N

3. Do you have ringing or other noises in your ears? Y / N

4. If yes,is the ringing constant? Y / N

5. Do you feel that you hear but do not always understand the words? Y / N

6. Do you have trouble hearing in crowds or other noisy situations? Y / N

7. Do you or have you ever worked around loud noise? Y / N

8. Do you have any noisy hobbies? Y / N if yes please list _____

9. Do you use firearms? Y / N

10. Do you use Hearing protection in the presence of loud noise? Y / N

11. Do you have a history of head injury? Y/N Please describe_____

12. Do you or have you ever experienced dizziness or balance problems? Y / N

13. If yes please describe without use of word “dizzy”_____

_____

14. Did your hearing problem progress slowly or suddenly? _____

15. Do you suffer from or have suffered from repeated ear infections? Y / N

16. Do you have any fullness or pressure in your ears? Y / N

17. Have you ever had ear surgery? Y/ N When? _____

18. Have you ever worn hearing aids? Y/N When?_____

19. Have you had a CT or MRI of the head? Y/N When?_____

Please list any current medications you take:_____

_____

Please list any Allergies:_____

_____

Circle any of the following that might apply:

Low birth weight	Respiratory problems at birth	Measles	Mumps
Meningitis	Illness with high fever	Rubella	Jaundice
Craniofacial Anomalies	Cytomegalovirus at birth (CMV)	Ototoxicity	Mastoditis
Kidney Disorders	High Blood pressure	Otosclerosis	Stroke
Meniere's Disease	Chemotherapy	Heart Attack	Diabetes
Cholesteratoma	Bell's Palsy	Mastoid Surgery	

Patient Record of Disclosure

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The right to restrict its disclosure to friends, family, etc. The individual is provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondences to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (please answer all that apply)

May we call your home phone? Y / N May we call your cell phone? Y / N

May we leave detailed messages on your answering machine? Y / N

May we leave a call back number only? Y / N May we leave a message with family? Y / N

May we contact you at work? Y / N

May we Fax you? Y / N Phone No._____

May we mail information to your home address on file? Y / N

You may disclose my PHI to the person or persons listed below:

_____ Relationship:_____

_____ Relationship:_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize the release of any medical information necessary to process any insurance claims, and I authorize payment of medical benefits directly to the provider of services for myself and/or dependants. I understand I am responsible for any deductibles, co-insurance or amounts for services not covered by the insurance carrier.

Signature: _____ Date:_____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or in my behalf to ADHS, for any services furnished me by one or more said Audiologists. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents any information needed to determine these benefits or the benefits payable for related services. In assigned Medicare claims, the Audiologist agrees to accept the charge determination of the Medicare Carrier as the full charge, and patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductibles are based upon the determination of the Medicare Carrrier.

Signature:_____ Date:_____

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I consent to the use or discloser of my protected health information by Advanced Diagnostics & Hearing Solutions (ADHS) for the purpose of analyzing, diagnosing, or providing treatment to me, obtaining payment for my health care bills or conduct health care operations of ADHS. I understand that analysis, diagnosis, or treatment of me by ADHS may be conditioned upon my consent as evidenced by my signature.

I understand I have the right to request a restriction as to how my protected Health care information is used or disclosed to carry out treatment, payment, or health care operations of this practice. ADHS is not required to agree to the restrictions I may request. However, if ADHS agrees to a restriction I request, the restriction is binding on ADHS.

I have the right to revoke this consent, in writing, at any time, except to the extent that ADHS has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created and received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present, future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may indentify me.

I have been provided with a copy of the Notice of Privacy Practices of ADHS and understand that I have a right to review the Notice of Privacy Practices to prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of ADHS. This Notice of Privacy Practices for Practitioner also describes my rights and duties of the ADHS with respect to my protected Health Information

_____ _____

Signature of patient or personal representative Printed Name of Patient

_____ _____

Date of signing Description of Personal Representative's Authority

_____

STAFF USE ONLY

_____ _____ Patient was presented with Notice of Privacy Practices

Staff Initials but did not sign acknowledgement

Comments:_____