HEARING SCIENCE

New Patient Information

Date: _____

PERSONAL INFORMATION

Patient name (last): (first):

Street Address:

City: State: Zip:

Cell or Home phone: ( ) Social Security #

Date of Birth: () Male() Female Email Address:

Employer: Work phone: ( )

Contact person: Relationship: Phone: ( )

INSURANCE

(Please give our front staff your ID card(s) to be copied)

A. Primary person/agency responsible for payment:

ID# or Group #:

Insurer's Address:

Insurer's Phone:

Is there another Health Plan? () yes ( ) no If yes, complete "B"

B. Other Insurance Name:

ID# or Group #:

Insurer's Address:

Insurer's Phone:

Do you have Medicare ? For billing purposes, we will need you to bring this card on the day of your appointment, thank you!

REFERENCE

Who may we thank for referring you? () Yellow pages () Internet _____
() Physician _____ () Advertisement _____
() Word of Mouth _____ () Other:_____

Who have you seen for your hearing?

Family Physician: Phone:

Hearing Science
Privacy Policy

Patient Consent for Use and Disclosure
Of Protected Health Information

- I hereby give my consent for Hearing Science to use and disclose protected health information (*PHI*) about me to carry out ***treatment, payment*** and ***health care operations (TPO).***

I have the right to review the Notice of Privacy Practice prior to signing this consent.

- **Hearing Science** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Hearing Science**.

- With this consent, **Hearing Science** may call my home or other alternative location and leave a message on voicemail or in person with reference to any items that assist the practice in carrying out *TPO*, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including test results, among others.

- With this consent, **Hearing Science** may mail to my home or other alternative location any items that assist the practice in carrying out *TPO*, such as appointment reminder cards and patient statements.

- With this consent, **Hearing Science** may e-mail to my home or other alternative location any items that assist the practive in carrying out *TPO*, such as appointment reminder cards and patient statements

- I have the right to request that **Hearing Science** restrict how it uses or disclose my *PHI* to carry out *TPO*. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement

- By signing this form I am consenting to allow **Hearing Science** to use and disclose my *PHI* to carry out *TPO*.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke, Hearing Science my decline to provide treatment to me.

_____ _____
Signature of Patient or Legal Guardian Print Patient's Name

_____ _____
Date Print Name of Parent or Legal Guardian (if applicable)

Comments: _____

_____

Patient History Information

Name_____

MEDICAL HISTORY

Yes No Have you seen a doctor in the past six months regarding your ears or hearing?
Yes No Have you ever had your hearing tested?
If yes, when_____by whom_____
Yes No Have you ever had any type of ear surgery?
If yes, type of surgery_____
Yes No Do you take medicine every day?
For what condition_____
Yes No Do you have any other medical conditions that might be related to your ears or hearing?
If yes, explain_____

ABOUT YOUR EARS:

Do you have any of these symptoms?

Yes No Deformity of the ear
Yes No Drainage from the ear
Yes No Sudden or rapid loss of hearing in the past 90 days
Yes No Acute or chronic dizziness
Yes No Ringing in the ears
Yes No Chronic ear infections
Yes No Have you ever seen a doctor for wax removal?
Yes No Do you ever have pain in your ears?
Yes No Is there a concern of Speech and Language delay? (for child)
Which is your poorer ear? Same Right Left

ABOUT YOUR HEARING:

Do you experience difficulty with the following?

Yes No Understanding conversation
Yes No Hearing in a crowd
Yes No Hearing by telephone
Yes No Hearing television
Yes No Does anyone else in your family have a hearing problem?
What relationship?_____
Yes No Do you now or have you ever worn a hearing aid?
If yes, how long ago was it purchased_____
How long have you had a hearing problem?_____

Who referred you to us?_____

Signature_____ Date_____

HEARING SCIENCE

FINANCIAL POLICY

Thank you for choosing Hearing Science as your hearing health care provider. Our goal is 100% patient satisfaction.

1. All patients must complete the Patient Information Form and sign our Financial Policy before seeing the Audiologist.
2. Charges for professional services are due at the time of service.
3. We offer a 60-day trial/return on all hearing aids. If you return the hearing aid(s), we will refund your deposit within fourteen days.
4. **Medicare:** Medicare only covers a limited number of professional services, and hearing aids are not covered. If there are services that may be billed to Medicare, we will bill for those services. The patient must cover the balance of the bill.
5. **HMO (Medicare and non-Medicare):** If you belong to a HMO for which we are a participating provider, you only need to pay for the co-pays and deductibles. If we are not a participating provider, we will investigate your benefits to determine whether we can provide service.
6. **Other insurance:** We may accept assignment of some insurance benefits. If your insurance company has not paid your account within 45 days, the balance may be charged to you. If we do not accept assignment, we require 50% of the bill to be paid at the time of service. The balance is your responsibility, regardless of the insurer's payment decision. Please be aware that some, and perhaps all, of the services provided may be non-covered services. To bill your insurance, we require your insurance information and an original claim form.

Authorization to release insurance information and assignment of benefits:
I hereby authorize Hearing Science to furnish any information to my insurance carrier concerning this illness or condition and I hereby assign to the audiologist all payments for medical services rendered and all major medical benefits**. I understand that I am financially responsible for any unpaid balance due**.

X _____ Date: _____
Signature of Patient or Responsible Party

X _____ Date: _____
Signature of Co-Responsible Party

WE ACCEPT CASH, CHECKS, VISA AND MASTERCAR

Marketing HIPAA Disclosure

Authorization for the Use or Disclosure of Protected Health Information

I consent to the use or disclosure of my protected health information (including audiograms) by Hearing Science ("Provider") for the purpose of diagnosing or providing hearing care and treatment to me.

I understand that diagnosis or treatment of me by Provider may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out hearing care and treatment. Provider is not required to agree to the restrictions that I may request. However, if Provider agrees to a restriction that I request, the restriction is binding on Provider.

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

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

I consent to Provider's use or disclosure of my PHI for purposes of delivering relevant product and/or technology marketing communication to me. I acknowledge that Provider may receive financial remuneration from the manufacturer in connection with such communications.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority