# NO SHOW AND LATE CANCELLATION POLICY

This policy has been established to help us serve you better and is effective 7/14/2014.

It is necessary for us to make appointments in order to see our patients as efficiently as possible; therefore, we request that if you must cancel your appointment you provide at least 24-hours' notice. This will enable another person who is waiting for an appointment to be scheduled during that appointment time. NO SHOWs and LATE CANCELLATIONs delay the delivery of care to other scheduled patients. We make every effort to help our patients keep their appointments by calling the day before their appointment to remind them of the time and confirm their attendance.

A NO SHOW is defined as missing a scheduled appointment.

A LATE CANCELLATION is defined as cancelling an appointment without calling 24 hours in advance of the scheduled appointment.

**A charge of $50.00 will be assessed for each NO SHOW or LATE CANCELLATION.**

We understand that situations arise, occasionally, when an appointment cannot be kept and adequate notice is not possible such as for medical emergencies. These situations will be considered on a case-by-case basis, and fees may be waived with management approval.

Patients who do not appear for their appointment without calling to cancel will be considered a NO SHOW. Patients who NO SHOW two or more times in a 12-month period may be dismissed from the practice and will be denied future appointments.

***NO SHOW and CANCELLATION fees are the sole responsibility of the patient.***

Our practice firmly believes that a good staff/patient relationship is based upon mutual understanding and open communication. Questions regarding NO SHOW and/or LATE CANCELLATION fees should be directed to Mrs. Tammy Wood, Administrative Coordinator, at 936/632-2252.

Please sign that you have read, understand and agree to this NO SHOW and LATE CANCELLATION Policy.

| | |
|---|---|
| Patient Name (Please Print) | Date of Birth |
| Signature of Patient or Patient Representative | Date |

# *INITIAL REGISTRATION*

*08/15/15*

Thank you for choosing AUDIOLOGICAL SERVICES as your hearing health care provider. AUDIOLOGICAL SERVICES is committed to providing professional, quality, hearing health care. Following is a statement of the Financial Policy. All patients are required to read, sign and complete this insurance form before seeing the hearing health care provider. Full Payment Is Due At Time Of Service. Cash, checks, Visa, Master Card or Discover and/or an extended payment plan with prior approved credit are accepted options.

INSURANCE RESPONSIBILITY STATEMENT: Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on various contracts. I understand that insurance is a method for me to receive reimbursement for fees I have paid for services rendered. It is my responsibility to pay the deductible, co-insurance, and other balances not paid by my insurance. I understand that AUDIOLOGICAL SERVICES files insurance forms as a courtesy and gives me an estimate of my insurance coverage. AUDIOLOGICAL SERVICES will assist me in receiving reimbursement as much as possible, but I am responsible for my account.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and instruct my insurance carrier(s) to make payment directly to AUDIOLOGICAL SERVICES for the expense of benefits otherwise payable to me. I understand that I am financially responsible to AUDIOLOGICAL SERVICES for charges incurred. I further assign all right payment due me for services rendered under said policies. This assignment will remain in effect until revoked by me

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that I received a copy of Audiological Services' Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice is in the reception area and that any revised Notice of Privacy Practices will be made available.

AUTHORIZATION TO RELEASE INFORMATION: I authorize AUDIOLOGICAL SERVICES to release the records relating to my identity and/or other health care information, by telephone in writing or pictorial, to my health care and/or service provider(s). I authorize the release of the same information to insurance carrier(s) and fiscal intermediaries or their representatives for reimbursement or utilization review. Also, I authorize AUDIOLOGICAL SERVICES to share my medical information with _____.

By signing below I represent that all information provided by me is true and that I have read and understand the above paragraphs regarding insurance responsibility, assignment of insurance benefits, acknowledgement of Notice of Privacy Practices and authorization to release information.

## *PATIENT INFORMATION:*

DR / MR / MRS / MS / MISS: _____ DATE OF BIRTH: _____/_____/_____
MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
PHYSICAL ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
CONTACT PHONE #1: _____ HM WK CELL CONTACT PHONE #2: _____ HM WK CELL
CONTACT PHONE #3: _____ HM WK CELL CONTACT PHONE #4: _____ HM WK CELL
EMAIL ADDRESS: _____ SKILLED NURSING FACILITY: NO / YES
PARENT'S NAME (IF MINOR): _____ SPOUSE/PARTNER NAME: _____
MARITAL STATUS: Single / Married / Other PATIENT'S SS#: _____
REFERRAL SOURCE: DR TV Newspaper Phone Book Internet Friend (Name): _____

## *INSURANCE INFORMATION*

PRIMARY INS. CO: _____ POLICY #: _____ GRP #: _____
POLICY HOLDER'S NAME: _____ POLICY HOLDER'S DOB: ____/_____/_____
POLICY HOLDER'S EMPLOYER: _____
PATIENT RELATIONSHIP TO POLICY HOLDER: Self / Spouse / Child / Other

SECONDARY INS. CO: _____ POLICY #: _____ GRP #: _____
POLICY HOLDER'S NAME: _____ POLICY HOLDER'S DOB: ____/_____/_____
POLICY HOLDER'S EMPLOYER: _____
PATIENT RELATIONSHIP TO POLICY HOLDER: Self / Spouse / Child / Other
IS THERE OTHER INSURANCE THAT MAY PAY FOR SERVICES? YES / NO

_____ _____
*Signature of Patient/Responsible Individual Date* *Signature of Witness Date*

# HEARING CASE HISTORY

NAME: _____ DOB: ____/____/____ AGE: _____ Sex: M / F DATE: _____
Last First MI

**REFERRING PROFESSIONAL:** _____ **CURRENT COMPLAINT/DIAGNOSIS:** _____

PLEASE CIRCLE THE TREATMENT RECEIVED FOR CURRENT COMPLAINT? None Medication Surgery Aural Rehabilitation

PLEASE CIRCLE ANY OF THE FOLLOWING PROCEDURES PERFORMED FOR CURRENT COMPLAINT:

CT SCAN WHEN? ____/____/____ RESULTS? _____

MRI WHEN? ____/____/____ RESULTS? _____

ENG (Balance/Dizziness Testing) WHEN? ____/____/____ RESULTS? _____

X-RAYS WHEN? ____/____/____ RESULTS? _____

ARE YOU CURRENTLY PREGNANT? (Circle One) NO YES WHICH TRIMESTER? (Circle One) First Second Third

PLEASE PROVIDE A LIST ANY **MEDICATION**(S) / HERBS **TAKEN REGULARLY** AND FOR WHAT CONDITION(S): _____

_____

HAVE YOU EVER BEEN GIVEN DRUGS THAT YOU WERE TOLD MIGHT AFFECT YOUR HEARING/BALANCE? (Circle One) NO YES

PLEASE CIRCLE ANY OF THE FOLLOWING CURRENT OR HISTORICAL **MEDICAL CONDITIONS** THAT APPLY:

**CARDIOVASCULAR** ATHEROSCLEROSIS / HEART ATTACK / HEART DISEASE / HYPERTENSION / STROKE **EAR DEFORMITY** R / L

**ENDOCRINE**: DIABETES MELLITUS: (Circle One) JUVENILE / ADULT ONSET THYROID DISEASE YEAR OF DIAGNOSIS? _____

**GASTROINTESTINAL** DIVERTICULOSIS / GERD / IBS / LIVER DISEASE **HEMATOLOGIC/LYMPHATIC** ANEMIA / LYMPHOMA / LEUKEMIA

**IMMUNOLOGIC** AIDS **GENITOURINARY** KIDNEY DISEASE **MUSCOLOSKELETAL** ARTHRITIS / FIBROMYALGIA / GOUT / TENDINITIS

**NEUROLOGICAL** FACIAL WEAKNESS / FREQUENT HEADACHES / MENINGITIS / NEUROPATHY / SEIZURES

**PSYCHIATRIC** ADD / ADHD / ALZHEIMER'S / ANXIETY / AUTISM / DEPRESSION / OCD / PTSD / SCHIZOPHRENIA

**RESPIRATORY** ASTHMA / COPD / EMPHYSEMA / PNEUMONIA / SLEEP APNEA / UPPER RESPIRATORY INFECTION

**CANCER**: YEAR OF DIAGNOSIS? _____ LOCATION IN BODY? _____

TREATMENT? _____

**HEAD INJURY**? NO / YES CAUSE? _____ WHEN? _____ LOST CONSCIOUSNESS? NO / YES AFFECTED HEARING? NO / YES

DID INJURY CAUSE? CONCUSSION DIZZINESS SKULL FRACTURE TINNITUS VERTEBRAL FRACTURE WHIPLASH

**OTHER MAJOR DISEASES, ILLNESSES, INJURIES OR ACCIDENTS**? _____

PLEASE COMPLETE THE FOLLOWING SOCIAL BEHAVIORS THAT APPLY:

MILITARY HISTORY _____ RECREATIONAL HISTORY _____ OCCUPATION _____ RETIRED? NO / YES

ALCOHOL USE _____ CAFFEINE USE _____

GENERAL STRESS LEVEL _____ TOBACCO: SMOKING _____ SMOKELESS _____

CIRCLE IF EXPOSED TO: **TOXIC CHEMICALS** **ORGANIC SOLVENTS** **ASPHYXIANT GASES** **HEAVY METALS**

PLEASE LIST ANY OF THE ABOVE: _____

**EXCESSIVE NOISE EXPOSURE?** CONSTRUCTION ENGINES (AUTO / BOAT / MOTORCYCLE / SKIMOBILE) EXPLOSIONS FACTORY FARMING

FIRE / POLICE DEPARTMENTS FOUNDRY GUNFIRE (MILITARY / OCCUPATIONAL / RECREATIONAL) HEAVY EQUIPMENT LOGGING / LUMBER INDUSTRY

MINING POWER TOOLS PRINTING LOUD MUSIC (AMPLIFIED / LIVE) TRANSPORTATION AIRPLANE / BOAT / TRAIN / TRUCK)

OTHER? _____ DURATION? _____ WHEN? _____

PLEASE CIRCLE ANY OF THE FOLLOWING CURRENT OR HISTORICAL **OTOLARYNGOLOGICAL** MEDICAL CONDITIONS THAT APPLY:

ALLERGIES / BELL'S PALSY / CHOLESTEATOMA / EAR FULLNESS / EAR PAIN / EAR PRESSURE / FACIAL PAIN / NUMBNESS / PARALYSIS

LABYRINTHITIS / MASTOIDITIS / OTOSCLEROSIS / SINUSITIS / OTHER? _____

HAVE YOU HAD ANY PROBLEMS WITH YOUR JAW OR YOUR TEETH? CLICKING GRINDING INJURY MISALIGNMENT PAIN SURGERY

EARWAX PROFESSIONALLY REMOVED: HOW OFTEN? _____ BY WHOM? _____

**EARACHES / INFECTIONS**: R / L ACUTE RECURRENT CHRONIC DRAINAGE? NO / YES CLEAR / COLORED? _____

TREATMENT? _____

AGE OF FIRST OCCURRENCE? _____ AGE OF LAST OCCURRENCE? _____ AVERAGE NUMBER OF INFECTIONS PER YEAR? _____

**OTIC SURGERY**: R L TONSIL- & ADENOIDECTOMY PLACEMENT OF PRESSURE-EQUALIZING TUBE(S) STAPEDECTOMY TYMPANOPLASTY

OTHER? _____ WHEN? _____

HAVE YOU HAD ANY OTHER EAR PROBLEMS OR EAR INJURY? NO / YES PLEASE EXPLAIN _____

PREVIOUS HEARING EVALUATION: _____ _____ _____

Location Year Results

**HEARING LOSS**: R L ACUTE CHRONIC FLUCTUANT PROGRESSIVE SUDDEN **ANY CHANGE** IN LAST 90 DAYS? NO / YES

WHEN DID YOU FIRST NOTICE A CHANGE IN YOUR HEARING? _____ DID YOU EXPERIENCE ILLNESS ACCIDENT OTHER INCIDENT? NO / YES

DO YOU HAVE DIFFICULTY UNDERSTANDING SPEECH? NO / YES IN QUIET IN NOISE WHEN USING THE CELL OR TELEPHONE

DO YOU HAVE DIFFICULTY HEARING SPECIFIC SOUNDS? NO / YES SOFT OR WEAK SOUNDS HIGH-PITCHED SOUNDS TV OR RADIO

ARE LOUD SOUNDS MORE UNPLEASANT THAN PREVIOUSLY? NO / YES

**TINNITUS?** R / L CONSTANT FREQUENT OCCASIONAL **SOUNDS LIKE**? _____ HOW LONG? _____

WAS ILLNESS, ACCIDENT OR OTHER SPECIAL CIRCUMSTANCE ASSOCIATED WITH THE ONSET OF YOUR PRESENT TINNITUS? NO / YES

PLEASE EXPLAIN _____

ON A SCALE OF 1 (NOT VERY) – 10 (EXTREME), HOW WOULD YOU RATE THE **SEVERITY** OF YOUR TINNITUS? 1 2 3 4 5 6 7 8 9 10

ON A SCALE OF 1 (VERY LOW) – 10 (VERY LOUD), HOW WOULD YOU RATE THE **LOUDNESS** OF YOUR TINNITUS? 1 2 3 4 5 6 7 8 9 10

HOW MUCH EFFORT IS REQUIRED TO IGNORE YOUR TINNITUS? VERY LITTLE SOME CONSIDERABLE I CAN NEVER IGNORE IT!

DOES THE TINNITUS LOUDNESS CHANGE BECAUSE OF ANY ALCOHOL / ASPIRIN / CAFFEINE / PRESCRIPTION PAIN KILLERS / SMOKING?

DOES THE TINNITUS LOUDNESS CHANGE BECAUSE OF ALLERGIES, CLENCHING TEETH, FATIGUE, ILLNESS, NOISE EXPOSURE, STRESS

DOES YOUR TINNITUS INTERFERE WITH SLEEP? NO / YES FALLING ASLEEP STAYING ASLEEP OTHER _____

DOES YOUR TINNITUS MAKE YOU FEEL IRRITABLE OR NERVOUS TIRED OR ILL UNABLE TO RELAX NO

HAS YOUR TINNITUS MADE YOU FEEL UNCOMFORTABLE TO BE IN QUIET UNABLE TO CONCENTRATE UNPLEASANT WITH OTHERS

HAVE YOU CHANGED JOBS BECAUSE OF YOUR TINNITUS? NO / YES

HAVE YOU MADE OTHER SIGNIFICANT CHANGES IN YOUR LIFESTYLE BECAUSE OF YOUR TINNITUS? NO / YES

HAVE YOU PREVIOUSLY SOUGHT MEDICAL HELP FOR YOUR TINNITUS? NO / YES WHERE? _____ WHEN? _____

HAVE YOU TRIED ANY OF THE FOLLOWING TYPES OF TREATMENT FOR YOUR TINNITUS? ACUPUNCTURE BIOFEEDBACK HYPNOSIS

DRUG THERAPY MASKING OTHER? _____

**VERTIGO**: BPPV LIGHT-HEADEDNESS ACTIVE / INACTIVE MENIERE'S DISEASE ROTARY NAUSEA

HOW OFTEN? RARELY SOMETIMES FREQUENTLY ALWAYS DATE OF ONSET? _____

DO YOU KNOW WHAT TRIGGERS YOUR EPISODES? NO / YES EXPLAIN _____

FAMILY HISTORY OF HEARING LOSS, DIZZINESS, EAR SURGERY, HEARING AIDS, KIDNEY DISEASE? WHO? _____

_____

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING? CHICKEN POX DIPHTHERIA GERMAN MEASLES (3-DAY, RUBELLA)

HEPATITIS MALARIA MEASLES MONONUCLEOSIS MUMPS RHEUMATIC FEVER SCARLET FEVER SYPHILIS TUBERCULOSIS

WHOOPING COUGH OTHER COMMUNICABLE DISEASE _____

DO YOU **OWN** A HEARING AID(S)? NO / YES EAR(S) FIT? R / L DO YOU **WEAR** A HEARING AID(S)? NO / YES AGE? _____

TYPE: ANALOG / PROGRAMMABLE / DIGITAL STYLE: B/C mBTE BTE mRITE RITE CROS ITE HS ITC MC CIC IIC COCHLEAR IMPLANT

(R) Make/Model/SN: _____ (L) Make/Model/SN: _____

YEAR OF FIRST FITTING: _____ ASSESSMENT OF CURRENT AID(S): _____

ADDITIONAL PERTINENT INFORMATION: _____

_____

_____