Please Allow the Receptionist to Copy All Your Insurance Cards and ID Card.
Please PRINT and Complete All Sections Below - Thank you!

PATIENT INFORMATION:

Name: ______________________________ Date of Birth: ____________ Gender: M / F

Mailing Address: ______________________________ Apt #:______ City: ____________ Zip: __________

Physical Address: ______________________________ Apt #:______ City: ____________ Zip: __________

SSN: ______________ Email: ______________________ OK to contact regarding your PHI? **Y N**

Home Phone #: ______________________ May we leave a message related to your PHI on this machine? **Y N**

Cell Phone #: ______________________ May we leave a message related to your PHI on this machine? **Y N**

Marital Status: ______________________ Spouse/Partner/Parent: ______________________

Spouse/Partner/Parent Phone #: ______________ May we leave a message related to your PHI on this machine? **Y N**

Employer/Occupation: ______________ / ______________ Work Phone #: ______________

Employer's Address: ____

INSURANCE INFORMATION:

Primary Ins. Name:______________ ID#:______________ Group #:__________ Co-Pay $:________

Secondary Ins. Name:______________ ID#:______________ Group #:__________ Co-Pay $:________

Workers Compensation Insurance:

☐ Labor & Industries ☐ HearPO ☐ Other Self-insured Company: ______________

Claim #:__________ Date of Injury:__________ Employer At The Time Of Injury:______________

RESPONSIBLE PARTY (NOT your insurance; responsible party for bill):

Person responsible for Bill (**Name, not your insurance**):______________________________

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other:______________________

If other than SELF please provide us with the information:

Date of Birth: ____________ SSN: ______________ Home Phone #: ______________

Home Address: Street: ______________________ Apt #:______ City: __________ Zip:__________

Work Phone #: ______________ Cell Phone #: ______________ Employer's Phone #:______________

Employer:______________________ Employer's Address: ______________________

Please continue on to page two

PRIMARY CARE PHYSICIAN INFORMATION:

Have you ever seen a physician for your ears/hearing? Who? When? ____

Purpose of today's visit: ____

*(**Insurance Patients:** if the purpose of your today's visit is a hearing test with an audiologist, please note that this will be a diagnostic hearing evaluation which is a series of complicated hearing tests performed by a licensed specialist to determine the type and degree of the hearing loss. This is not a routine hearing test which is a part of the Preventive Care Services)*

Do you have a **written** physician's referral? **Y / N**

*(**Medicare patients**: in order for Medicare to consider coverage for charges for your hearing evaluation you are required to have a written physician referral that shows medical necessity before seeing a specialist. Hearing tests performed for the purpose of fitting or adjusting hearing aids considered non-covered service by Medicare)*

Do you want a copy of today's results sent to your physician? **Y / N** Physician Name: ____________________________

HOW DID YOU HEAR ABOUT US?

☐ Physician (Name):______________________ ☐ Mailer/Post card:______________ ☐ TV Ad ☐ Insurance Company

☐ Phonebook: ☐ Dex ☐ Lewis County ☐ Yellow Book ☐ Other Phonebook:______________________________

☐ Online/Newspaper:___________________ ☐ Friend/Relative (Name): ___________________ ☐ Other: ___________

ASSINGNMENT OF BENEFITS – FINANCIAL AGREEMENT

All of the information above is complete and accurate to the best of my knowledge. I certify that I am the patient or authorized general agent of the patient authorized to furnish the information requested. I hereby give lifetime authorization for payment of insurance benefits to be made directly to the Hearing Healthcare Center, Inc. and any assisting specialists, for services rendered. I authorize HHC or the insurance company to release any information necessary for claims being processed. I further agree that a photocopy of this agreement shall be as valid as the original.

I have read over, fully understand, and agree with HHC's *Notice of Financial Policies and Responsibility Agreement.* The responsibility for payment of my account remains with me at all times even though I may have an insurance claim or legal suite pending. If I fail to pay my balance in time I understand that service charges mentioned in the HHC's *Notice of Financial Policies* may be added to my balance. If my account becomes delinquent, I agree to pay any additional charges to collect my unpaid bills, including but not limited to, reasonable attorney fees, court costs, and collection agency fees.

By my signature below I acknowledge that the Hearing Healthcare Center reserves the right to release any patient information to an outside collection agency. The venue of said legal action may be laid in Thurston and Lewis Counties, WA.

____________________________________ ____________________________________
Signature of Patient or Personal Representative Date

____________________________________ ____________________________________
Print Name of Patient or Personal Representative Relationship to Patient

Office Use Only

______________________________ ______________________________
Received By **Processed By**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES / HIPAA AUTHORIZATION FORM

I acknowledge that I have received a copy of the Notice of Privacy Practices for the Hearing Healthcare Center, Inc. The notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services or in the performance of office's health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Notice of Privacy Practices is also posted in the facility.

Hearing Healthcare Center, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I may request a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby authorize use or disclosure of protective health information about me as described below.

1. The following specific person(s) / facility may receive disclosure of protected health information about me:

Name: ____ Relationship to Patient: _______________________

Name: ____ Relationship to Patient: _______________________

☐ I elect not to have my PHI disclosed to anyone but myself.

2. I understand that the information used or disclosed may be subject to re-disclosure by the person(s) / facility receiving it, and would then no longer be protected by federal privacy regulations.

3. I may revoke this authorization by notifying Hearing Healthcare Center, Inc. in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

____________________________________ ________________________________

Signature of Patient or Personal Representative | Date

____________________________________ ________________________________

Print Name of Patient or Personal Representative | Relationship to Patient

A copy of this completed, signed, and dated form must be given to the Patient or Personal Representative.

Office Use Only

________________________________ ________________________________

Received By | **Processed By**

Children's Case History

Please Print

Patient Name: ________________________________ **Today's Date:** _________________

Child's Date of Birth: ___________________________ Sex: ☐ Male ☐ Female

Person completing form: _________________________ Relationship to child: ____________

Please circle the most appropriate answer

Do you have any concerns regarding your child's hearing?	YES	NO
Do you have any concerns regarding your child's speech and language?	YES	NO
Has your child been examined by a physician for ear trouble?	YES	NO
Has your child ever been given a hearing test?	YES	NO
Does hearing loss run in the family?	YES	NO
Does your child suffer from allergies or frequent colds?	YES	NO
Does your child suffer from ear infections?	YES	NO
How many in the last year? 1 2-3 4+		
Have developmental milestones (crawling, walking, etc.) been normal?	YES	NO
Has your child had any injury to their head or ears?	YES	NO
Were there any complications at birth?	YES	NO
Has your child ever worn a hearing aid?	YES	NO
Does your child exhibit any hearing loss behavior?	YES	NO

Describe:

____

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