Hearing Healthcare Center, Inc.

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: _____

ASSIGNMENT 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

_____ _____

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Health Questionnaire

Patient Name: _____ **Date:** _____

	YES	NO
Do you have any problems hearing?	☐	☐
How long? _____ Which ear? ☐ Right ☐ Left ☐ Both		
Have you had a hearing test before?	☐	☐
What year? _____		
Have you ever worn a hearing aid?	☐	☐
How long? _____ Which ear? ☐ Right ☐ Left ☐ Both		
Do your family or friends complain about your hearing?	☐	☐
Do you keep the TV volume high?	☐	☐
Does anyone in your family, including cousins, have a hearing loss?	☐	☐
Do you have ☐ dizziness ☐ ear pain ☐ headache ☐ hypertension?	☐	☐
Do you hear noises (tinnitus) in your ear or head?	☐	☐
Which ear? ☐ Right ☐ Left ☐ Both		
How often? ☐ Constantly ☐ Unsure ☐ Occasionally		
Have you ever had a skull fracture or concussion?	☐	☐
Have you ever had any ear surgery?	☐	☐
Which ear? ☐ Right ☐ Left ☐ Both		
Have you ever had any ear infections?	☐	☐
Which ear? ☐ Right ☐ Left ☐ Both		
Have you ever been exposed regularly to loud noises?	☐	☐
If yes, where? _____ How long? _____		
Have you taken radiation treatment to the head or neck?	☐	☐
Do you take any medications regularly?	☐	☐
If yes, for what? _____		
Have you ever been given drugs that you were told might affect your hearing or balance?	☐	☐
What were the drugs? _____		

Have you ever taken any of these drugs:

☐ Cisplatin	☐ Carboplatin	☐ Dihydrostreptomicin	☐ Gentamicin	☐ Nitrogen mustard	☐ PTU
☐ Vancomycin	☐ DCM	☐ Netilmicin	☐ Streptomycin	☐ Tobramycin	☐ Quinidex
☐ Atabrine	☐ Amikaci	☐ Neomycin	☐ Capreomycin	☐ Vincristine	☐ Plaquenil
☐ Kanamycin	☐ Chloroquine	☐ Bumex (bumetanide)	☐ Erythromycin	☐ Lasix (furosemide)	
☐ Quinine Sulfate	☐ Mefloquine (lariam)		☐ Desferroxamine	☐ Edecrin (ethacrynic acid)	

Check any that you have had:

☐ Meningitis	☐ Malaria	☐ High Blood Pressure	☐ Mumps
☐ Diabetes	☐ Heart Trouble	☐ Scarlet Fever	☐ Allergies