NORTH GEORGIA AUDIOLOGY & HEARING AID CENTER

THREE LOCATIONS

JOHNS CREEK - 4045 Johns Creek Pkwy Suite B, Suwanee, GA 30024 770-814-1260
GAINESVILLE - 726 South Enota Drive, Suite B, Gainesville GA 30501 678-971-4647
WOODSTOCK - 203 Woodpark Place Suite B-100, Woodstock, GA 30188 770-726-8948

Patient Name: _____ Appointment Date: _____
Date of Birth: _____ Age: _____ Gender: **Male Female** Title:_____
Marital Status: **Single Married Widowed** Social Security Number: _____
Address:_____City:_____State:_____Zip:_____
Home Phone: _____ Cell Phone: _____
Email Address: _____
Emergency Contact:_____Phone:_____
Current Employment: **Full-time Part-time Retired Unemployed Stay at Home Parent Student**
Current Employer (If retired list prior occupation): _____ Position: _____
Whom May We Thank for Referring You: _____
Primary Care Physician: _____
Reason for your Appointment: _____

Insurance Information – Please give insurance cards to our front office staff in order to make a copy.

Primary Insurance: _____ Member ID: _____
Insured's Name: _____ Relationship to the Insured: _____
Secondary Insurance: _____ Member ID: _____

***Medicare requires a Physician Order when seeing an Audiologist for a Hearing Test. May Fax to:**
Johns Creek Office Fax: 770/814-1261 Gainesville Office Fax: 678/971-4648
Woodstock Office Fax: 770/234-6977

AUDIOLOGICAL HISTORY

Do you feel you have hearing loss? **Yes No** Which ear? **Right Left Both**
If you answered yes, which best describes it? **Gradual Fluctuating Sudden**
When did you first notice your hearing loss? _____
_____
What do you think is the cause of your hearing loss? _____
_____
Have you ever had a hearing evaluation? **Yes No When/Where?** _____
_____
Have you ever worn or tried a hearing aid? **Right Ear Left Ear Both Ears**

What type and/or style of hearing aid: _____
Please describe your experience: _____
_____
Which situations do you have difficulties? _____

Please check all medical conditions that apply:

_____ Developmental Disorders/Delays — Please explain: _____
_____ Dizziness or Unsteadiness — Accompanied by: **Vomiting** **Nausea** **Ear Noises**
_____ Ear Deformity — **Right Ear** **Left Ear** **Both ears**
_____ Ear Drainage — **Right Ear** **Left Ear** **Both ears**
_____ Ear Pain — **Right Ear** **Left Ear** **Both ears**
_____ Family History of Hearing Loss — Who? _____
_____ History of Ear Infections — **Right Ear** **Left Ear** **Both ears**
When? _____
_____ History of Ear Wax Buildup — **Right Ear** **Left Ear** **Both ears**
_____ History of Noise Exposure — Please describe_____
_____ Previous Ear Surgery — **Right Ear** **Left Ear** **Both ears**
When? _____
_____ Tinnitus/Ringing/Noises in the ears — **Right Ear** **Left Ear** **Both ears**
How Often? _____
_____ Other — Please describe:_____
_____

MEDICAL HISTORY

Have you experienced any of the following major medical conditions:

_____AIDS/HIV	_____Diphtheria	_____ Mumps	_____ High Blood Pressure
_____Appetite Change	_____Encephalitis	_____ High Fevers	_____ Scarlet Fever
_____Arthritis	_____Fatigue	_____ Influenza	_____ Stroke
_____Blood Disorders	_____Genetic Disorder	_____ Latex Allergy	_____ Tonsillitis
_____Cancer	_____Headaches	_____ Malaria	_____ Typhoid
_____Chicken Pox	_____Head Injury	_____ Measles	_____ Vascular Problems
_____Diabetes	_____Heart Problems	_____ Meningitis	_____ Other_____

List All Current Medications (over the counter, prescriptions, or recreational): May Attach List

Name: _____ Dosage: _____ How Often: _____ Method:_____
Name: _____ Dosage: _____ How Often: _____ Method:_____
Name: _____ Dosage: _____ How Often: _____ Method:_____
Name: _____ Dosage: _____ How Often: _____ Method:_____
Name: _____ Dosage: _____ How Often: _____ Method:_____

Have you used a tobacco product one or more times in the past 24 months? **Yes** **No**
If yes, how often have you used a tobacco product in the past 24 months? _____
If yes, what type(s) of products have you used? _____
Have you experienced dizziness, unsteadiness, imbalance or vertigo? **Yes** **No**
If yes, please describe: _____
How often does this occur? _____
Are you feeling dizzy today? **Yes** **No**
Is dizziness accompanied by: **Nausea** **Ringing in the Ear** **Hearing Loss** **Visual Disturbances**
Have you fallen within the past 12 months? **Yes** **No**
If yes, how many falls have you experienced in the past 12 months? _____
If you have fallen, have you been injured? **Yes** **No** Type of Injury: _____

NGA YOUR LINK TO BETTER HEARING
NORTH GEORGIA AUDIOLOGY & HEARING AID CENTER

INSURANCE AND FINANCIAL POLICIES:

You may request to view the North Georgia Audiology, LLC schedule of fees for typical services provided.
We are also happy to provide you with a written estimate of the cost of any service.

INSURANCE/CLAIMS SUBMISSION:

In the event that NGA is an In-Network or participating provider with your insurance carrier, the office will submit a claim for payment of billable procedures performed and, if applicable, any hearing aid benefit. All coinsurance, specialist copays, and deductibles are due at time of service.

In the event NGA is not a participating provider with your insurance carrier, payment in full for services rendered will be due at time of service. A maximum out-of-pocket charge for typical hearing testing will not exceed $123. If you have an out-of-network benefit for hearing testing and/or hearing aids, appropriate documentation may be provided to you for your own filing for re-imbursement.

If you have Medicare and a secondary insurance with a hearing aid benefit, we must first file with Medicare for a denial.

I, and/or my dependents have insurance with: _____and assign directly to NGA all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I understand any expenses incurred in collecting any monies due to this account is my responsibility.

FINANCIAL POLICIES:

NGA will bill a return check fee of $50. There is a $50 “no show” fee for any missed appointment not cancelled prior to twenty-four hours of a scheduled appointment.

NGA accepts cash, checks, Visa, MasterCard, American Express, Discover, Care Credit and AllWell for services.

ACKNOWLEDGEMENT:

I understand the insurance and financial policies of Johns Creek Audiology, LLC.

_____ _____

Signature of Patient or Guardian of a Minor **Date**

YOUR LINK TO BETTER HEARING
NORTH GEORGIA AUDIOLOGY & HEARING AID CENTER

Authorization & Release for the Use and/or Disclosure of Protected Health Information
HIPAA

Patient Name:_____ **Date of Birth:**_____

I request and authorize North Georgia Audiology & Hearing Aid Center to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or care provider, the disclosed information may no longer be protected by federal privacy regulations.

I prohibit NGA from using and disclosing medical information to any person or entity other than required by HIPAA regulations with the exception of the following person(s) or entities:

Name:_____ Phone:_____

Name:_____ Phone:_____

I authorize North Georgia Audiology & Hearing Aid Center to use my protected health information for marketing related to audiological/health-related products or services only. This correspondence may include: appointment reminders, newsletters, new technology announcements, upgrade and/or discount offers.

NGA WILL NOT DISCLOSE PROTECTED INFORMATION WITH THIRD PARTY MARKETING PROVIDERS.

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by North Georgia Audiology & Hearing Aid Center.

I understand that this authorization is in effect for the duration of "active patient status" which is defined as up to 5 years after the last appointment or until revocation is received. I may revoke this authorization at any time by giving written notice to the **North Georgia Audiology & Hearing Aid Center.**

I authorize the use of my protected health information as set forth above. I understand that this authorization is voluntary and that North Georgia Audiology & Hearing Aid Center cannot condition my treatment, services, etc. on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: HIPAA

North Georgia Audiology & Hearing Aid Center's Notice of Privacy Practices 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 will be posted in the reception area and that any revised Notice of Privacy Practices will be made available.

_____ _____

Printed Name of Patient or Personal Representative **Date**

_____ _____

Signature of Patient or Personal Representative **Date**