heartland
HEARING CENTERS LLC

Hear Better. Live Better. Guaranteed.

PATIENT INFORMATION:

Date: _____

Name: _____ Preferred Name: _____
(First) *(Middle Initial)* *(Last)*

Home Phone #: (_____)_____ Cell Phone #: (_____)_____

E-mail: _____ Date of Birth: _____ Sex: M F

Address: _____

_____
(City) *(State)* *(Zip)*

Secondary Address *(if applicable)*: _____

_____
(City) *(State)* *(Zip)*

Occupation: _____
(If retired, prior occupation)

Marital Status: Single / Widowed / Married Name of Spouse *(if applicable)*: _____

Emergency Contact: _____
(Name) *(Phone)* *(Relationship to Patient)*

Physician: _____ Phone: _____

Responsible Party: _____
(Name) *(Relationship to Patient)*

_____
(Address)

_____
(City) *(State)* *(Zip)* *(Phone)*

How did you hear about us? *(please circle)*
Direct Mail / Newspaper Ad / Telephone / Friend / Physician / Website / Yellow Pages

Referred by: _____Physician Referral: _____

HEARING HEALTH HISTORY

Do you have any allergies? ☐ Yes ☐ No (if Yes) Please list: _____

Are you insulin-dependent diabetic? ☐ Yes ☐ No

Are you currently taking any medication? ☐ Yes ☐ No (if Yes) Please list: _____

Do you have arthritis? ☐ Yes ☐ No

Do you have ringing in your ears? ☐ Yes ☐ No

Have you previously had a hearing test? ☐ Yes ☐ No (if Yes) By whom? _____

Have you received any medical or surgical treatment for a hearing loss? ☐ Yes ☐ No
(if Yes) When? _____ Physician/ENT _____ Phone _____
Additional information about treatment? _____

Do you currently wear hearing aids? ☐ Yes ☐ No (if Yes) ☐ Both ☐ Left ☐ Right
(if Yes) Is there anything you could improve about your current hearing instrument/s? _____
_____

COMMUNICATION ASSESSMENT

What have others said or noticed about your hearing/understanding or communication ability?_____
_____
_____

How long have you noticed any difficulty?_____
_____

What concerns you most about your hearing/understanding and communication difficulties?_____
_____
_____

What is it that NOW made you decide to come here today?_____
_____
_____

What are some other environments or situations where hearing and communication are difficult for you?
_____
_____

List the environments/listening situations where communication is difficult for you in order of importance:

1_____ 5_____

2_____ 6_____

3_____ 7_____

4_____ 8_____

If I can help you hear and communicate more effectively in the places or situations you've described, is that the RESULT you're looking for? _____

_____

INSURANCE INFORMATION

Primary Insurance: _____

_____

Name of Policy Holder: _____

Relationship of Patient to Policy Holder:

_____

Policy Number: _____

Group Number: _____

Insured's Date of Birth: _____

Secondary Insurance: _____

_____

Name of Policy Holder: _____

Relationship of Patient to Policy Holder:

_____

Policy Number: _____

Group Number: _____

Insured's Date of Birth: _____

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)

I hereby authorize the release of any information necessary to provide Audiologic or Medical History to my Audigy Certified Practice or Primary & Referring Physicians. I also authorize the release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to my Audigy Certified Practice. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account and for professional services or purchases rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I hereby give my Audigy Certified Practice permission to treat my concerns.

Please sign below to acknowledge that you have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

_____ _____

A copy of this signature is as valid as the original. *Date*

Signature of Parent or Guardian, if patient is a minor: _____

Please list below the names of those you authorize to have access to your accounting information:
(example: spouse, child)

_____

_____

_____

Hear Better. Live Better. Guaranteed.

CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, you are granting consent to Heartland Hearing Centers LLC to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read all of it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our web site at www.heartlandhearingcenter.com. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

_____ _____

Signature Date