



Lisa Papa, M.S., CCC-A, Licensed Audiologist
Jennifer P. Davis, M.A., Licensed Audiologist
Sharon Johnson, H.I.S., Hearing Instrument Specialist

Patient Information Form

Name: _____ Male Female
(LAST) (First) (M)

Birthdate: _____ Age: _____ Married Single Widowed Divorced

SSN: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address (if different than mailing address):

City: _____ State: _____ Zip : _____

Phone: _____ Alternate Phone: _____

E-mail address: _____

Employer Name, Address, and Phone:

Emergency Contact: _____

Emergency Contact Phone: _____ Relationship: _____

Primary Physician: _____

Referred by: _____

Phonebook Website Patient Doctor Magazine Self

Responsible Party (Guarantor) if same as above check here

Name: _____

Address: _____

Phone: _____ Relationship to Patient: _____

If patient is a child:

Biological child

Foster child

Adopted child

Insurance Information

Name of Insurance Company:

Address: _____ Phone: _____

Policy #: _____

Group#: _____

Name of Insured if not the patient: _____

Insured's SSN: _____ Insured's Date of Birth: _____

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this form and certify this information is correct to the best of my knowledge.

Signature of Patient or Guardian

Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your patient records will be reviewed by your attending physician and staff members of this practice. The information will be used for the purposes of treatment, payment and day-to-day healthcare operations (including referrals, the scheduling of tests and labs, etc.) We may use this information to remind you of upcoming appointments, and to offer information to you concerning treatment and other healthcare services. We take every precaution to protect your health information through administrative, physical and technical safeguards.

You have the right under this Notice of Privacy Practices to:

*Request restrictions

*Receive confidential communications

*Inspect & copy protected health information

*Amend information

*Receive an accounting of disclosures for any purposes other than treatment, payment, and day-to-day operations.

Consent to Use and Disclosure of Health Information For Treatment, Payment, or Health Care Operations

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand this information serves as a:

*Basis for planning my care and treatment.

*Means of communication among the many health professionals who contribute to my care.

*Use of name and address for direct marketing purposes.

*Source of information for applying my diagnosis and surgical information to my bill.

*Means by which a third-party payer can verify that services billed were actually provided.

*Tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

**All patients must sign "Patient HIPAA Consent Form", if the patient refuses to sign the consent, the physician will not provide medical treatment.

I understand and have been provided with a Notice of Privacy Practices and understand that a more complete description of information uses and disclosures will be provided upon written request.

If you feel that your medical record has not been properly protected please notify our privacy officer at Advanced Professional Hearing Aid Services, Inc. We maintain the right to modify the privacy practices and will make the new notices immediately available for review. I have read and understood the information provided.

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

*Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);

*Obtaining payment from third party payers (e.g. my insurance company);

*The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date: _____

Print Patient Name: _____

Signature: _____

Relationship to Patient: _____

Witness: _____

Advanced Professional Hearing Aid Services, Inc.

318 Lee Street West

Suite 201

Charleston, WV 25302

304-345-7102



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Patient Authorization of Disclosure

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The patient may revoke or change this authorization at any time with a written request.

I wish to be contacted in the following manner (Check all that apply) :

Home Telephone:

- O.K. to leave message with detailed information
- Leave message with call-back number only

Work Telephone

- O.K. to leave message with detailed information
- Leave message with call-back number only

Written Communication

- O.K. to leave message with detailed information
- Leave message with call-back number only

Patient Signature: _____ Date: _____

- Patient refused to sign

In a further effort to protect your health information and the confidentiality of your healthcare, we ask that you designate below to whom the staff at Advanced Professional Hearing Aid Services, Inc. may discuss your healthcare and scheduling needs as well as billing issues that may arise.

- Only disclose information to myself and/or

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Patient Name: _____ Date: _____

1. Chief Complaint: Hearing Loss (Right ear/ Left ear/ Both) Tinnitus/Ringing Dizziness
 Difficulty hearing (in quiet in noise) Telephone (Right Ear/ Left ear/ Both)
2. Do you think your hearing is changing? Yes No (Gradual Sudden)
3. Have you ever been exposed to loud noise, either recently or in the past? Yes No
If so, please mark all that apply:
 Farm Machinery Music Hunting/Shooting Factory Noise
 Power Tools Military Jet Engines Other: _____
4. Do you have any of the following symptoms?
 Deformity of the ear Drainage of the ear Ear Pain Acute or chronic dizziness/Imbalance
 Tinnitus (Ringing) Sudden or rapid loss within the past 90 days
5. Have you ever had your hearing tested? Yes No If so, when was your last test?

6. Have you seen an Ear, Nose, and Throat Physician? Yes No
If so, who did you see? _____ When? _____
7. Have you ever had surgery that may have affected your hearing? Yes No
If yes, type? _____
8. Is there a history of hearing loss in your family? Yes No If so, who? _____
9. Have you ever had an ear infection? Yes No If yes, as a child as an adult
10. Please check any of the following that you currently have or have had in the past:
 Arthritis Heart Trouble Measles Scarlet Fever
 Asthma Hepatitis Meningitis Sinusitis
 Bell's Palsy High Blood Pressure Mumps Stroke/TIA
 Diabetes HIV Neurological Symptoms
 Head Injury Malaria Parkinson's Visual Trouble-Loss/Sight
11. Please rank the following in order of importance (1 being most important-4 being least important), if a hearing aid is recommended for you:
___ Improved hearing in quiet ___ Improved hearing in noise
___ Cosmetic appearance ___ Expense
12. If you are currently using a hearing aid, or have in the past, please answer the following:
Which ear is/was aided? Right Left Both
How long have you been using a hearing aid? _____