Mid-Valley Hearing Center

Lisa Papa, M.S., CCC-A, Licensed Audiologist
Jennifer P. Davis, M.A., Licensed Audiologist

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

(Over)

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 Mid-Valley Hearing Center, LLC. 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: _____

Mid-Valley Hearing Center

3855 Teays Valley Road

Hurricane, WV 25526

304-760-8804

Lisa Papa, M.S., CCC-A, Licensed Audiologist
Jennifer P. Davis, M.A., Licensed Audiologist

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 Mid-Valley Hearing Center 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 _____

Lisa A. Papa, M.S., CCC-A, Licensed Audiologist
Jennifer P. Davis M.A., Licensed Audiologist
3855 Teays Valley Road Hurricane, WV 25526
304-760-8804 Fax: 304-760-8815
www.hearingaidwv.com

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? _____