Patient Information Form

Date ___/___/___

Patient Name _____ **DOB** ___/___/___
First Middle Last

Patient SSN _____ **Sex (circle one)** M F

Address _____
Street City State Zip

Home Phone (_____)_____-_____ ☐ Preferred **Cell Phone** (_____)_____-_____ ☐ Preferred

May we contact you via e-mail? Y N **E-Mail Address** _____

Employer/Occupation _____ ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Retired ☐ Student

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Long Term Commitment

Spouse Name _____ **Emergency Contact** _____

Emergency Contact Relationship _____ **Phone** (_____)_____-_____

If patient is under the age of 18, this section must be completed by a responsible party.

Responsible Party Name _____ **DOB** ___/___/___
First Middle Last

Responsible Party SSN _____ **Responsible Party Relationship** _____

Address _____
Street City State Zip

Home Phone (_____)_____-_____ **Cell Phone** (_____)_____-_____

Primary Care Physician _____ **Phone** (_____)_____-_____

Address _____

Please present your insurance card(s) and photo identification to our office staff at check in.

Primary Insurance _____ **ID #** _____

Insured Name _____ **Relationship** _____ **Insured DOB** _____/_____/_____

Secondary Insurance _____ **ID #** _____

Insured Name _____ **Relationship** _____ **Insured DOB** _____/_____/_____

How did you hear about us?

☐ Mail ☐ Newspaper Ad ☐ Insurance ☐ Yellow Pages ☐ Website ☐ Employer
☐ Referred by Friend_____ ☐ Referred by Physician_____
☐ Other _____

Reason for Appointment_____

_____

Please read carefully and sign below.

_____(initials) I give permission to *The Audiology Center, Inc.* to release information, verbal and written, contained in my medical record and other related information, to my insurance company, and related healthcare providers. This authorization will remain in effect indefinitely or until a new authorization is executed by me.

_____(initials) I authorize my insurance benefits to be paid to *The Audiology Center, Inc.* I understand that I am responsible for my account balance being paid in full even if an insurance claim is filed. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.

_____(initials) I understand that many insurance companies require that a referral to *The Audiology Center, Inc.* prior to my appointment. I will make every effort to ensure that this is handled in a timely manner by my primary care physician.

_____(initials) I understand that payment may be made by cash, check, debit card or credit card. I understand that should my account become delinquent that my billing information will be forwarded to a collection agency.

_____(initials) I understand that payment for any co-pays or deductibles will be collected prior to my visit. I also understand that in the event that a hearing aid Is recommended to me by *The Audiology Center, Inc.*, the specific costs related to the hearing aid will be discussed with me at that time and a contract will be executed.

_____(initials) I have received a copy of *The Audiology Center, Inc.* privacy policy (HIPPA) regarding my health information but also understand that a copy is available to me upon my verbal or written request. I also understand that a copy of this privacy policy hangs at the receptionist's desk of *The Audiology Center, Inc.* and I will be offered a copy as any changes are made to the policy. I will contact the Office Manager should I have a problem or complaint, so that any issue may be resolved.

_____(initials) I understand that the preferred method of contact for *The Audiology Center, Inc.*, regarding appointments, tests results and account questions, will be my **preferred phone number** as indicated on the front of this form.

____Yes ____ No *The Audiology Center, Inc.* may leave a voicemail regarding appointments, test results and account questions, including my personal health information on my home/cell phone. Any specific instructions for calling are as follows:_____

_____

_____

I have read and completed all of the information on this form in its entirety. I certify that the information is true and correct to the best of my knowledge and hereby give *The Audiology Center, Inc.* permission to treat my concerns.

Patient Signature _____ **Date** _____/_____/_____

Responsible Party Signature _____ **Date** _____/_____/_____

If patient is under the age of 18.

MEDICATION LIST

Name _____ **DOB** ____/____/____ **Date** _____

As part of your hearing healthcare history, we need to know about any medications you take. Please provide the following information below. Please be sure to include ALL medications. Please use the back of this form if additional space is needed.

IF YOU HAVE A LIST OF MEDICATIONS, WE CAN MAKE A COPY AND YOU WILL NOT NEED TO COMPLETE THIS FORM.

Are you currently using tobacco products? O No O Yes **How long?** _____

If yes, what form do you use? O Dip/Snuff O Smoking O E-cig

Medication Name	Dosage (how many milligrams is the dose?)	How often do you take it? (how many times per day/week/month, etc.)	How do you take it? (by mouth, injection, lotion, etc.)	Reason for taking? (blood pressure, cholesterol, etc)
EXAMPLE: Lipitor	**50 mg**	**daily**	**mouth**	**cholesterol**

Specializing in

- *Hearing Evaluations*
- *Industrial Audiology*
- *Aural (Re)Habilitation*
- *Hearing Aid Repair*
- *Assistive Listening Devices Digital, Programmable, and Standard Hearing Aids*

The Audiology Center

For Your Convenience

- *Most Credit Cards Accepted*
- *On Site Lab for Repairs*

We Listen So You Can Hear

1364 Ebenezer Road • Rock Hill, SC 29732 • (803) 327-1900 • Fax (803) 327-4146
www.myAudiologyCenter.com

Medical Records Release Form

Patient Name _____ **DOB** ____/____/____ **Social Security #** _____
First MI Last (Last 4 Digits Only)

I authorize the office of (Provider/Entity) _____

Address _____

Phone Number (_____)_____-_____ **Fax Number** (_____)_____-_____

To disclose/release the following records to The Audiology Center, Inc. via fax to (803) 327-4146:

☐ Entire Patient Record ☐ Last Audiogram ☐ Any Information Relating To Patient's Hearing Loss

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In order for us to discuss your health information or your account, we require your written permission. Please list the name(s) and relationship of anyone that you authorize us to discuss your information with. This authorization will remain in effect until you notify The Audiology Center, Inc. in writing.

I authorize The Audiology Center, Inc. to release my medical records to the following:

☐ Self (parent or guardian if patient is a minor)

☐ Referring/Primary Care Physician - _____

☐ Other - _____

Patient Signature _____ **Date** _____/_____/_____

Witness Signature _____ **Date** _____/_____/_____

Jacquelyn D. Niedringhaus, Au.D. **Sarah Vair, Au.D.**
Doctors of Audiology

Fellow, American Academy of Audiology • Member, SC Academy of Audiology • National Hearing Conservation Association
Audiological Resource Association • American Auditory Society

A. Notifier: The Audiology Center

B. Patient Name: _____ **C. Insurance Carrier:** _____

Identification Number: _____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If your insurance carrier doesn't pay for **D. Hearing Evaluation** below, you may have to pay. Your insurance carrier does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance carrier may not pay for the **D. Hearing Evaluation** below.

D. Hearing Evaluation	E. Reason Your Insurance Carrier May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. Hearing Evaluation** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but your insurance carrier cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D. Hearing Evaluation** listed above. You may ask to be paid now, but I also want my insurance carrier billed for an official decision on payment, which is sent to me on an explanation of benefits. I understand that if my insurance carrier doesn't pay, I am responsible for payment, but **I can appeal to my insurance carrier** by following the directions on the explanation of benefits. If my insurance carrier does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D. Hearing Evaluation** listed above, but do not bill my insurance carrier. You may ask to be paid now as I am responsible for payment. **I cannot appeal if my insurance carrier is not billed**.

☐ **OPTION 3.** I don't want the **D. Hearing Evaluation** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if my insurance carrier would pay.**

H. Additional Information:

This notice gives our opinion, not an official insurance carrier decision. If you have other questions on this notice or billing, call **your insurance carrier directly.**

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

Patient Medical History

Date ___/___/___

Patient Name _____ **DOB** ____/____/____
First Middle Last

- **Chief complaint:** _____

_____

How long has this been an issue? _____ Gradual or Sudden? _____

- **Please list the three (3) situations where you have the most difficulty hearing.**
  1. _____
  2. _____
  3. _____

- **Do you have the following:**

Difficulty hearing while using the telephone?	Yes	No
Difficulty hearing while watching television?	Yes	No
Pain in your ear?	Yes	No
Drainage from your ears?	Yes	No
Facial tingling/numbness?	Yes	No
Taste disorder?	Yes	No
Loudness discomfort?	Yes	No

- **Do you experience:**

Tinnitus (ringing in ears)? Yes No Right Ear or Left Ear Constant or Occasional
How long have you had it? _____
Describe how it sounds: _____

Dizziness? Yes No Spinning or Off Balance Nausea? Yes No
How long does it last? _____
What seems to cause the dizziness? _____

- **Do you currently use Hearing Aid Devices?** Yes No
  How long have you used them? _____
  Do you find your current hearing aids helpful? Very Somewhat Not

- **Do you have a family history of hearing loss?** Yes No
  If yes, please describe: _____

- **Noise Exposure History:**

Occupational	Yes	No	If yes, please describe:_____
Recreational	Yes	No	If yes, please describe:_____
Firearms	Yes	No	If yes, please describe:_____
Military	Yes	No	If yes, please describe:_____

Please list any other instances where you have been exposed to noise (ex. musician, farming, power tools): _____

- **Are you diabetic?** Yes No If yes, how long? _____ Do you use insulin? Yes No

- **Have you had ear surgery?** Yes No
  If yes, please describe: _____

- **Have you had your hearing evaluated before?** Yes No
  If yes, when was your last evaluation? _____
  Were any follow up recommendations made? _____

- **Have you been diagnosed with an ear related medical problem?** Yes No
  If yes, please describe: _____

- **Please check any of the following that you currently have or have had in the past:**

☐ Eye Problems (such as blurred vision, pain)
☐ Nose, Throat, or Mouth Problems (such as trouble swallowing, nose bleeds, dental issues, pain)
☐ Cardiovascular Symptoms (such as hypertension, chest pain, swelling, palpitations)
☐ Respiratory Symptoms (such as shortness of breath, cough, wheezing)
☐ Gastrointestinal Issues (such as nausea, vomiting, weight changes, diarrhea, pain)
☐ Musculoskeletal Symptoms (such as joint pain, swelling, recent trauma)
☐ Neurological Symptoms (such as numbness, headaches, seizures, muscle weakness)
☐ Psychiatric Issues (such as depression, anxiety, compulsions)
☐ Endocrine Symptoms (such as frequent urination, hot flashes)
☐ Hematologic/Lymphatic Symptoms (such as bleeding gums, bruising, swollen glands)
☐ Allergic/Immunologic Symptoms (such as hives, asthma, itching, immune deficiency)

- **Please check any of the following major medical conditions that you have experienced:**

☐ AIDS/HIV
☐ Appetite Change
☐ Arthritis
☐ Blood Disorders
☐ Cancer
☐ Chicken Pox/Shingles
☐ Diabetes
☐ Diphtheria
☐ Encephalitis
☐ Fatigue
☐ Genetic Disorders
☐ Headaches
☐ Head Injury
☐ Heart Problems
☐ High Blood Pressure
☐ High Fevers
☐ Influenza
☐ Malaise
☐ Malaria
☐ Measles
☐ Meningitis
☐ Mumps
☐ Scarlet Fever
☐ Stroke
☐ Tonsillitis
☐ Typhoid
☐ Vascular Problems
☐ Other: _____

- **Do you have any allergies?** Yes No
  If yes, please describe: _____

- **Please use the space below to list any other illnesses, surgeries, injuries or hospitalizations since birth and their date(s) of occurrence:** _____

_____
_____
_____