Clear Hearing Center ✲ Sun City

PATIENT INFORMATION

Today's Date: ____/____/____

Last Name _____ First Name _____ M.I. _____

Preferred Name (Nickname) _____

Date of Birth: ___/___/___ Gender M ☐ F ☐ Home Phone # (___)_____ Cell Phone # (___)_____

Address _____ City _____ State _____ Zip Code _____

Email address _____

Employer _____ Occupation _____ Employer Phone # (___)_____

Spouse's name _____ Spouse's phone # (___)_____

Nearest relative not living with you _____ Phone # (___)_____

Whom may we contact in case of an emergency? _____

Relationship _____ Phone # (___)_____

Primary Care Physician _____ Phone # (___)_____

Whom may we thank for referring you to our office? _____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account due for any professional services rendered. I have read all the information on this sheet and certify that this information is correct to the best of my knowledge. I will notify Clear Hearing Center in Sun City of any changes in my health status or in the above information.

Signature: _____ Date: _____

Parent Signature (if minor): _____ Date: _____

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Patient Name: Last:_____ First:_____ M.I.____

Medical History:
(Please circle which applies)

Yes No Have you seen a doctor specializing in diseases of the ear?
Yes No Have you ever had your hearing tested?
If yes, please give date_____ by whom_____
Yes No Have you ever had any type of ear surgery?
If yes, what type of surgery _____ by Dr. _____
Yes No Do you take medicine every day?
If yes, for what condition(s)? _____

_____
Yes No Do you have any other medical conditions?
If yes, please explain _____

_____
Yes No Have you ever had a serious illness in the past that may have affected your hearing?
(i.e., scarlet fever, meningitis, mumps, etc.) _____
Yes No Have you been exposed to high levels of sound? (i.e., farm equipment, power tools, lawn mowers, chain saws, firearms)_____
If yes, was hearing protection used? Yes No Sometimes

About Your Ears:
(Please circle which applies)

Yes No Deformity of the ear
Yes No Drainage from the ear
Yes No Sudden or rapid loss of hearing in the past 90 days
Yes No Acute or chronic dizziness
Yes No Have you seen a doctor for wax removal?
Yes No Do you ever have pain in your ears?
Yes No Do you ever experience ringing or noises in your ears?
If yes: Left Right or Both If yes, is the sound: Constant or Intermittent

About Your Hearing: Do you experience difficulty with the following?
(Please circle which applies)

Yes No Understanding conversations
Yes No Hearing in a crowd
Yes No Hearing by telephone
How long have you had difficulty in communicating? _____
Yes No Is one ear better than other? If yes: Left or Right
Yes No Has anyone else in your family been diagnosed with hearing loss?
What relationship? _____
Yes No Do you now or have you ever worn a hearing aid?
If in the past, when? _____

Signature: _____ **Date:** _____/_____/_____

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Acknowledgement of Receipt of Notice

I hereby acknowledge that I have read this medical Practice's "Notice of Privacy Practices".

Yes ____ No ____ I wish to receive a copy of "Notice of Privacy Practices"

Signature: _____ **Date:** ____/____/____

Name: _____ Telephone# (___)_____

If not signed by the patient please indicate relationship:

- ☐ Parent or guardian if patient is a minor
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of patient (if different from above): _____

For Office Use Only:

Signed and Received By: _____

Acknowledgement Refused: _____

Efforts to Obtain:

_____

_____

Reasons for Refusal:

_____

_____

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Patient Financial Responsibility:

We appreciate your trust in Clear Hearing Center. As a courtesy, your consultation and comprehensive diagnostic evaluation is provided at no cost to you.

We ask that you read through the financial policy and sign the bottom prior to treatment.

I understand and agree that I am financially responsible for all charges for any and all services rendered. Payment is required upon fitting or an agreement of a payment plan. We accept cash or card (Visa, MasterCard, Discover, American Express, or CareCredit)

In the event I am prescribed Hearing Technology, I realize I have the **ultimate responsibility for verifying the coverage with my insurance.** I understand that while my insurance may confirm my benefits, conformation of benefits is not a guarantee of payment and that I am responsible for any balance not paid or denied by my insurance.

I understand that **Clear Hearing** will be happy to fill out the claim form, but I realize it is my responsibility to submit or mail the form for reimbursement. I realize that any follow up or dispute on claim payment is my responsibility.

I understand and agree that it is my responsibility to know if my insurance requires a preauthorization and that it is up to me to obtain that authorization. I understand that without this authorization, my insurance my not pay for any services and that I will be financially responsible for all services rendered.

I have read and agree to the terms of the above information. I understand payment is expected at the time of fitting and that I am responsible for any balance.

Patient Name: (Please Print): _____

PATIENT SIGNATURE: _____ **Date:** _____

The Notice of Privacy Practices is required by the Privacy Regulations stemming from the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Notice of Privacy Practices explains how your medical information may be used/disclosed and how you can get access to your medical information.

This practice is determined to protect the privacy of your medical information. As we provide service to you, we create and store health information (a medical record) that identifies you. It is often necessary to share or disclose this health information in order to provide treatment for you, obtain payment and to conduct healthcare operations in our office.

This Notice of Privacy Practices requires us to:

1. Keep your medical records private and to provide you with this notice.
2. Change our privacy practices and the terms of this notice at any time, ensuring our notice is effective, even for information recently obtained.
3. Before we make an important change in our privacy practices, we would change this notice and make the new notice available upon request.

The following is a description of the different circumstances that may require this practice to use or disclose your medical information:

1. Share medical data with another provider who is responsible for your care (physicians, audiologists, nurses, any other healthcare professionals, technicians, students in healthcare, or any other people who take care of you), make referrals and/or placing lab/prescription orders.
2. Share your health insurance plan information about a treatment you received at our practice when filing a claim for reimbursement or determination of benefits.
3. Disclose your medical information for our healthcare operations.
4. Share information about your condition(s), location and/or death to family member(s), or your personal representative(s). Prior permission by you will be obtained unless in case of emergency. If we are unable to obtain permission, we will share only the health information directly necessary for your healthcare.
5. Disclose medical information to a medical examiner to identify a deceased person or to determine the cause of death, or for tissue donations.
6. Medical information may be disclosed if you are military personnel, either active or a veteran, and if required by the appropriate authorities.
7. Share medical data to the public health and/or law enforcement official whose job is to prevent or control disease, injury or disability.
8. Share medical data to a representative from the Food and Drug Administration for the purpose of reporting adverse effects stemming from defective products, etc
9. Medical information may be disclosed when necessary to comply with Workers' Compensation.
10. Medical information may be disclosed when in response to a court and/or administrative order in a lawsuit or similar proceeding.

You have individual rights as part of the notice of Privacy Practices. As a patient of Clear Audiology, you have the right to:

1. Photocopies of your medical records on file and/or a copy of this Notice of Privacy Practices. If you need a photocopy, please notify the receptionist.
2. Receive a list of all the times your medical information has been shared by our office or our business associates, other than treatment, payment, healthcare operations and/or other specified exceptions.
3. Request we communicate with you about your medical information by different means or to different locations. This request must be made in writing to Clear Audiology.
4. Request a change to your health information if you think it is incomplete or inaccurate. However, if the audiologist, hearing healthcare professional or office personnel believe the patient's health information is complete and accurate, he/she can refuse to make the requested changes. This request must be made in writing to Clear Audiology.
5. Request a paper copy if you have received this Notice of Privacy Practices electronically. This request must be made in writing to Clear Audiology.