HEARING PROFESSIONALS

INTAKE FORM

For Office use only: ___________

Acct #: ________

Date: ________________

Patient Name: **Date of Birth:** **Male** ☐ **Female** ☐

First M.I. Last

Address:

Street City State Zip

Phone #:

Home Cell Work

E-mail Address: **Health Insurance:**

Family Doctor: City: State:

Patient Employer Name: **Occupation:**

Emergency Contact: **Emergency Contact Phone #:**

Marital Status:___ How were you referred to our office?:____________________

If patient is a minor, please fill out:

Guardian Name: **Guardian Phone #:**

Guardian Address:

Street City State Zip

PATIENT PRIVACY INFORMATION

Please list family members or other persons whom we may inform about your general medical condition, diagnosis, appointments or other health care information.

Name: **Phone #:** **Relationship:**

Name: **Phone #:** **Relationship:**

Can we share information about your general medical condition or appointments with your employer or school? Yes ☐ **No** ☐

Can confidential messages (ie. Appointment reminders) be left on your home answering machine or voice mail? Yes ☐ **No** ☐ **Work Voice Mail? Yes** ☐ **No** ☐

Can we send appointment reminders or requests to contact our office via postcard? Yes ☐ **No** ☐

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The undersigned hereby authorizes the staff of Hearing Professionals for consent to any and all care and attention which is deemed necessary by the staff at Hearing Professionals. I authorize Hearing Professionals to furnish complete information to my insurance carriers or its intermediaries regarding services rendered. I authorize contacting my employer or the employer which is providing the insurance coverage in assistance with getting my debt collected. I authorize the release of any and all information by fax and/or phoning of information as needed. I authorize contacting my family physician as needed. I hereby assign, transfer and convey payment and authorize said payment to be made directly to Hearing Professionals for any hearing benefits and/or devices, or proceeds of all claims, payable by any party, organization, etc. to or for discharge or completion of all outstanding obligations related to this medical treatment. I understand that I am financially responsible for all charges regardless of the reimbursement amount paid by my insurance. I further agree that this assignment will not be withdrawn or voided at any time until this account is paid in full and revoked by me in writing. A photocopy of this assignment is to be considered valid as the original.

Signature:____ Date: ______________________

CONSENT FOR TREATMENT OF A MINOR

I, __________________________ am the parent and/or legal guardian of the following child: ______________________, age ____, and hereby authorize the staff at Hearing Professionals for consent to any and all care and attention which is deemed necessary.

Signature: ______________________________Date: ______________

Witness: _______________________________

CONSENT OF VIDEO-RECORDING OF CONSULTATIONS

By signing below, I acknowledge that I have received the Hearing Professionals policy on Video-Recording consultations and I agree to this and any future consultations, as a patient at Hearing Professionals, being videoed and recorded for educational and training purposes only. I understand that I have the right to revoke my consent at any time by providing Hearing Professionals with written notice of my intent to revoke my consent to being videoed and recorded as set forth above.

Patient Name: ____
(Please Print)

Patient Signature: ______________________________ Date: ______________

Signature of Legal Guardian *(if applicable)*: ______________________________

NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received the Notice of Privacy Practices from Hearing Professionals.

Customer/Guardian Signature:___________________________Date: _________________

Witness Signature: ____________________________________Date: _________________

DOCUMENTATION OF FAILURE TO OBTAIN SIGNED AUTHORIZATION

On __________, 20___, we attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) ____

HEARING PROFESSIONALS

Notice of Privacy Practices

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

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 9/23/2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make the new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice dearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an Insurance company, or another third party.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care of Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or
- condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody to protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPPA.
Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit of a dispute, we may disclose your PHI in response to a court of administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHJ to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSURES O F PHI
Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of P H I for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice {or as otherwise permitted or required by law}. You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIG HTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of our health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except In the case where the disclosure Is to a health plan for purposes of carrying out payment or health care operations, and the information pertain solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location of your request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record{s} and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email).

QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you chose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Stephanie Steinhoff, Administrative Director

Telephone: 937-492-9982 Fax: 937-492-6460

Address: 2040 Michigan Street, Sidney OH 45365 Email: DirectorAdmin@hearingprosonline.com

Name:	**Date of Birth:**	**Date:**

Circle the Correct Answer:

Is this your first hearing test?	Yes	No		
If no, approximately when was your last hearing test?	1 year	2-3 years	>5 years	>10 years
What were the results?	Good	Bad	Don't Remember	

Have you ever had any of the following? (Circle all that apply)

Buzzing or ringing in the ears	Pressure or popping in the ears	Exposure to noise
Ear infections (child or adult)	Family history of hearing loss	Dizziness
Drainage from your ears	Ear Surgery	Ear Pain
History of falls	Diabetes	Depression
Heart Disease	Memory Loss	Kidney Disease

Hearing History (Circle Yes or No)

Yes	**No**	Have you noticed a drop in speech clarity and understanding?
Yes	**No**	Do you have difficulty hearing in background noise?
Yes	**No**	Do you feel people mumble or slur their words?
Yes	**No**	Do you prefer the TV or radio louder than others?
Yes	**No**	Have you ever avoided social occasions or family gatherings where listening may be difficult for you?
Yes	**No**	Do you frequently nod your head "yes" in agreement when you are not sure what someone said?
Yes	**No**	Do others raise their voices or move closer to help you hear more clearly?
Yes	**No**	Do you hear out of one ear better than the other ear?
Yes	**No**	Have you noticed a decline in short term memory?
Yes	**No**	Do you use an iPhone, iPad, or iPod?

In what situations do you feel you want/need better hearing? (Circle all that apply)

Watching TV	Outdoors	Over the Phone
Church	Crowded Noisy Places	Meetings
Concerts	In Restaurants	Lectures

For Office Use Only: *1 – 2 – 3 – 4 – 5* *(Pre-HAE **Patient** Questionnaire)*

Name: **Patient Name:** **Date:**

What is your perception of your spouse/friend/loved one's hearing? (Circle Yes/Sometimes/No)

Question			
Does a hearing problem cause him/her to feel embarrassed when meeting new people?	**Yes**	**Sometimes**	**No**
Does a hearing problem cause him/her to feel frustrated when talking to members of your family?	**Yes**	**Sometimes**	**No**
Does he/she feel handicapped by a hearing problem?	**Yes**	**Sometimes**	**No**
Does a hearing problem cause him/her to attend religious services less often than he/she would like?	**Yes**	**Sometimes**	**No**
Does a hearing problem cause him/her to have arguments with family members?	**Yes**	**Sometimes**	**No**
Does a hearing problem cause him/her difficulty when listening to TV or radio?	**Yes**	**Sometimes**	**No**
Do you feel that any difficulty with hearing limits or hampers his/her personal or social life?	**Yes**	**Sometimes**	**No**
Does a hearing problem cause him/her difficulty when in a restaurant with relatives or friends?	**Yes**	**Sometimes**	**No**
Do you feel he/she struggles with short-term memory loss?	**Yes**	**Sometimes**	**No**
Do you feel he/she has feelings of depression or anxiety?	**Yes**	**Sometimes**	**No**

Comments:

For Office Use Only: 1 – 2 – 3 – 4 – 5 *(Pre-HAE 3rd* ***Party*** *Questionnaire)*