ADVANCED AUDIOLOGY INSTITUTE

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Patient Information

□Mr. □Mrs. □Ms. □Dr. Gender: □ Male □Female
Name: ________________________________ Date of Birth: ______________ Age: ______________
Address: ______________________________ City/State/Zip:
____
Home Phone: ___________________________ Cell Phone: ____________________
Employer Name: ________________________ Employer Phone: _________________
Email: _______________________________ Is it okay to contact you via email and/or text? □Yes □No
Emergency Contact Name: ________________ Emergency Contact Phone: _______________________
Social Security Number: _________________ Referred By: ________________________________

Insurance Information

□ Work Related Injury Date of Injury __________ □Auto Accident related injury Date of injury __________
Primary Insurance: ______________________ Insurance Address:
____
Insurance Phone number: _________________ Name of Insured:
____
Policy Number: _________________________ Group Number:
____
Insured Date of Birth: ____________________ Insured Employer:
____

Secondary Insurance: _____________________ Insurance Address:
____
Insurance Phone number: _________________ Name of Insured:
____
Policy Number: _________________________ Group Number:
____
Insured Date of Birth: ____________________ Insured Employer:
____

HIPAA

I understand that as a part of my healthcare, Advanced Audiology Institute originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as: (a) a basis for planning my care and treatment (b) a means of communicating amount he many health professionals who contribute to my care (c) a source of information for applying my diagnosis and surgical information to my bill (d) a means by which a 3rd party payer(s) can verify that services billed were actually provided (e) a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a NOTICE OF INFORMATION PRACTICES that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges: (a) the right to review the notice prior to signing this consent/disclosure (b) the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare options.

I understand that Advanced Audiology Institute is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action I reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me permitted by Section 164.520 of the Code of Federal Regulations.

I understand that as party of this organization's treatment, payment or healthcare operations it may become necessary to disclose my protected health information to another entity (insurance company, referring physician, hospital, etc) and I consent to such disclosure for these permitted uses including disclosures via fax or email. In addition, I also give consent to Advanced Audiology Institute to disclose my protected healthcare information to the following person and/or people:
____.

Authorization to Release Information & Assignment of Benefits and HIPAA Consent

The above information is complete and correct. I authorize release of information as necessary to file a claim with my insurance company company and I assign benefits to Heppler Audiology PLLC dba Advanced Audiology Institute. We will gladly file your insurance claim, however, payment for co-pays and deductibles are required at the time services are rendered. We cannot guarantee payment to Heppler Audiology PLLC. We have an agreement with you, not your insurance company for payment. In the event your insurance company denies a claim, you will be responsible for all amounts not covered payable to Heppler Audiology. Parents/Guardians are responsible for services rendered to a minor. If you account is turned over to outside collections, you will be responsible for all costs of the court or outside collections agencies as well as an 18% collection fee.

I authorize release of all medical records to referring and primary care physicians and the insurance company as applicable. I authorize fax/email transmissions of medical records as necessary.

Patient/Guardian Signature: ___________________________ Date: __________ Relationship to Patient: ______________

Name: ______________________________ Date of Birth: ______________ Age: ____________

General History

Is this your first hearing exam? ▫Yes ▫No

If not, when was your last exam? __________________ By whom? ______________________________

What were the recommendations? ____

How long ago did you notice a decline in your hearing loss?

□Recently □1-3 Years □4-6 Years □7-10 years □more than 10 years

Have you ever used hearing instruments or assistive listening devices? □Yes □No

In which ear is your hearing poorest? □Right □Left □Same

Which ear do you use on the telephone? □Right □Left □Same

Do you experience frequent dizziness or unsteadiness? ▫Yes ▫No

Are you experiencing any drainage from the ear? ▫Yes ▫No

Are you experiencing any ear pain? ▫Yes ▫No

Do you have a family history of hearing loss? ▫Yes ▫No

Do you have a feeling of fullness in the ear(s)? ▫Yes ▫No

Do you have a history of ear infections? ▫Yes ▫No

Do you have a history of ear-wax build up? ▫Yes ▫No

Have you had an excessive exposure to noise? ▫Yes ▫No

Do you have a history of military service? ▫Yes ▫No

Do you have a history of firearm use? ▫Yes ▫No

Do you have sinus or allergy problems? ▫Yes ▫No

Are you experiencing Tinnitus (ringing in the ears)? ▫Yes ▫No

Medical History

Reason for today's appointment? ____

Allergies to any food, medications, plastics, etc? _____________________________________

Current Medications: ____

Are you diabetic? ▫Yes ▫No

Are you on blood thinner? ▫Yes ▫No

Do you have any blood clotting disorders? ▫Yes ▫No

Have you ever had ear surgery ▫Yes ▫No

If yes, type of surgery: ______________________

Please list all major surgeries: ____

Please list any serious illnesses: ____