FOREST AUDIOLOGY

15243 Forest Road, Suite D
Forest, VA 24551
(434) 266-9898
www.ForestAudiology.com

Patient's First Name: _____ Middle: _____ Last: _____

Salutations: ☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr. ☐Rev. Date of Birth: _____/_____/_____ Gender: M F

Who reffered you or how did you hear about us? _____

Patient's Address: (Street) _____

City: _____ State: _____ Zip: _____ Can we send you mail? ☐Yes ☐No

Primary Phone #: _____ ☐ Home ☐Mobile ☐ Work

Secondary Phone #: _____ ☐ Home ☐ Mobile ☐ Work

Mobile Phone Carrier: _____ Can we text you or leave a voicemail message? ☐Yes ☐No

Email Address: _____ Can we email you? ☐Yes ☐ No

For appointment confirmations, which do you prefer? ☐ Phone Call ☐Text Message ☐ Email

Favorite Hobbies: _____ Favorite Muscial Artist/ Genre: _____

Employer: _____ Occupation: _____

Spouse or Caregiver's Name: _____

Relation: _____ Phone # : _____

Person Responsible for Account (if patient is a minor)

Name: _____ Relation to Patient: _____

Home Phone #: _____ Business Phone #: _____

Employer/Occupation: _____ Social Security #: _____

Payment is expected at the time of service. We accept cash, check, and all major credit cards.

If my account becomes delinquent, I agree to pay all collection costs, including agency fees (33.3% on top of principal balance), court costs and attorney fees.

Signature: _____ Date: _____

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HEARING HISTORY FORM

Patient Name: _____ Date: _____

HEARING HISTORY:

Do you feel that you have a hearing problem? ☐ Yes ☐ No If so, for how long? _____

Do you notice hearing loss worse in one ear? ☐ Yes ☐ No If yes, which ear? ☐ Right ☐ Left

Was the onset gradual or sudden? ☐ Gradual ☐ Sudden

What do you feel caused the hearing problem? _____

Have you ever been exposed to loud noises at work or in your hobbies...

(e.g., guns, power tools, tractors, loud music, etc?) ☐ Yes ☐ No Explain: _____

Have you seen a physician for your hearing loss? ☐ Yes ☐ No If yes, physician name: _____

Have you ever had any surgery on your ears? ☐ Yes ☐ No Explain: _____

Do you have any dizziness or imbalance? ☐ Yes ☐ No Explain: _____

Do you have a history of ear infections? ☐ Yes ☐ No Explain: _____

Do you have any ringing in your ears? ☐ Yes ☐ No Explain: _____

Do you have any pain in your ears? ☐ Yes ☐ No Explain: _____

Do you have any drainage from your ears? ☐ Yes ☐ No Explain: _____

Do you have an ear deformity? ☐ Yes ☐ No Explain: _____

Does anyone in your family have hearing loss? ☐ Yes ☐ No If yes, relation to you: _____

HEARING AID HISTORY (if applicable):

Have you ever worn a hearing aid? ☐ Yes ☐ No When did you first start wearing aid(s)? _____

When did you purchase your current aid(s)? _____ Have the aid(s) been satisfactory? ☐ Yes ☐ No

MEDICAL HISTORY:

How is your general overall medical health: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

Do you have diabetes? ☐ Yes ☐ No Explain: _____

Have you ever had any radiation or chemotherapy? ☐ Yes ☐ No Explain: _____

Do you have an autoimmune disease? ☐ Yes ☐ No Explain: _____

Have you ever had any head trauma? ☐ Yes ☐ No Explain: _____

List any chronic illnesses: _____

List all current medications or provide a list: _____

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Insurance Authorization and Financial Policy

Thank you for choosing us as your audiology provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read, agree to and sign prior to testing or fitting of hearing aids.

Office Services: Responsibility for payment of your bill is your obligation regardless of insurance coverage. Insurance is filed as a courtesy to you. Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims. We want to make sure, however, that you understand payment of the service is your responsibility. You will also be responsible for all non-covered services, amounts exceeding allowed charges, co-pays and deductibles, including Medicare. All co-pays are due at time of service.

Cases Involving Litigation: We consider the patient, not the attorney, to be responsible for all fees.

Insurance Authorization: I hereby authorize Forest Audiology to furnish information to my insurance carriers and physicians concerning my illness or treatment, or my child's illness or treatment.

I also acknowledge responsibility for payment for all medical fees regardless of any insurance I may have to assist me in this responsibility. If for any reason the account should become delinquent. I agree to pay all collection and legal fees. I have read, understood, and agree to the above Financial Policy.

Payments

I authorize the release of any medical or other information necessary to process this claim. I also request payment of the government benefits either to myself or to the party who accepts assignment below.

I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ _____
Printed name of patient Date of Birth

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practice and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me with a revised Notice of Privacy Practice upon request.

Signature _____ Date _____

_____
Relationship to patient (if signed by a personal representative of the patient)

NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices is required by the Privacy Regulations stemming from the Health Insurance Portability and Accountability Act of 1996 (HIPAA). 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.

According to HIPAA regulations, you have the right to restrict the uses or disclosures of your information made for purposes of treatment, payment, and/or healthcare operations.

• Treatment is the provision, coordination or management of hearing health care. For example, we may use and disclose your information to consult with a third party or to refer you to other health care providers. We will get your written consent prior to making disclosures outside our practice for treatment purposes, except in emergencies.

• Payment includes the activities necessary to obtain reimbursement for the provision of hearing health care. For example, we may need to give your health plan information about treatment you received at our practice so your health plan will pay us or reimburse you for the treatment. We will get your written consent prior to making disclosures for payment purposes.

• Health care operations include the activities necessary for our practice to run its business operations. For example, we may use your information to review treatment and services and to evaluate the performance of our staff.

• We may use or share your information for health research. If you have any questions regarding our privacy practices or think we may have violated your privacy rights, please contact us at:

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If your concern is not resolved, you may also submit a written complaint to the US Department of Health and Human Services. If you choose to file a complaint, we will not retaliate in any way.

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. Update our privacy practices and the terms of this notice at any time, ensuring our notice is effective, even for information recently obtained.

3. We reserve the right to make an important change in our privacy practices and change this Notice to that effect. You may contact us to request a new copy of our Notice and we will make the new Notice available upon request.

The following is a description of the different circumstances that may require our 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. Provide treatment communications concerning treatment alternatives or other health related products or services, unless we or a business associate receive financial remuneration in exchange for the communication in which case we must receive your written authorization unless the communication is made face-to-face or involves gifts of nominal value.

4. Disclose medical information to a medical examiner to identify a deceased person or to determine the cause of death, or for tissue donations.

5. Medical information may be disclosed if you are military personnel, either active or a veteran, and if required by the appropriate authorities.

6. Share medical data to the public health and/or law enforcement official whose job is to prevent or control disease, injury, or disability.

7. Share medical data with a representative from the Food and Drug Administration for the purpose of reporting adverse effects stemming from defective products, etc.

8. Medical information may be disclosed when necessary to comply with Workers' Compensation.

9. Medical information may be disclosed in response to a court and/or administrative order in a lawsuit or similar proceeding.

10. In order to contact you for fundraising activities supported by our practice. You have the option to opt out of receiving these communications by sending a written request to the privacy officer.

11. For marketing purposes for which our practice or our business associates may receive remuneration, for a disclosure that constitutes a sale of protected health information, and in all other situations not described in this policy your written authorization will be obtained before our practice will use or disclose your health information to third parties outside our practice. You have the right to revoke such authorization by providing our practice with a written request to revoke the specific authorization.

12. If a use of disclosure is required by law, the disclosure will be made in compliance with the law and will be limited to such requirements. State and federal laws may be more stringent and may prohibit certain uses and disclosures identified above. When another law is more stringent than HIPAA, we will follow the more stringent requirements.

13. To business associates to perform functions on our practice's behalf, if the business associate has signed an agreement to protect the confidentiality of the information.

14. 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.

You have individual rights as part of the notice of Privacy Practices. As a patient of our practice you have the right to:

1. Request our practice to restrict uses and disclosures of your health information. However, we are not required to agree to the requested restriction unless you are requesting a restriction on the use and disclosure of your protected health information to a health plan for payment or healthcare operations and such information pertains to a healthcare item or service which you paid for in full and out of pocket. These requests should be made in writing to the address given in this Privacy Notice. In your request, you must tell us (a) what information you want to limit; (b) whether you want to limit our use, disclosure, or both, and (c) to whom you want the limits to apply.

2. Be notified upon a breach of any of your unsecured protected health information.

3. Request that we communicate with you regarding your confidential medical information by different means or to different locations. This request must be made in writing to our practice.

4. Request 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.

5. 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 our practice.

6. Receive a list of all the times your medical information has been shared by our office or our business associates for six years prior to the request date, other than treatment, payment, healthcare operations and/or other specified exception.

7. Request a paper copy if you have received this Notice of Privacy Practices electronically. This request must be made in writing to our practice.

8. You have the right to choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.