Gardner Audiology

TODAY'S DATE:				
Patient Name (First / Middle Initial / Last / Suffix)	Sex	Date of Birth	Age	Social Sec Number
Address (Street)	Preferred Language English Spanish Other:			
Address (City/State/Zip)	Home Phone Number		Cell Phone Number	
E-mail Address	Preferred Method of Communication Home Phone Cell Phone E-mail			
Marital Status: Single / Married / Divorced / Partner / Widowed				
Employment Status: Full Time / Part Time / Retired / Not Employed / Active Military				
Seasonal Address (Street/City/State/Zip)				
Do you have Power of Attorney? Yes / No If yes, name:	Power of Attorney's Phone Number			
Emergency Contact Name & Relation	Emergency Contact's Phone Number			
Primary Care Physician	Primary Care Physician's Phone Number			
Whom may we thank for referring you to us?	Phone Number			

Insurance Information. We will request to scan your ID and insurance card(s).			
Subscriber's Name (First/Middle/Last)			Date of Birth
Insurance Name	ID Number	Group Number	Relationship to Subscriber

Patient Authorizations

Insurance & Financial Authorizations:

I authorize the release of any information by Gardner Audiology to determine insurance benefits and assignment of benefits for payment of services provided to me. I request that my insurance carrier make payments to Gardner Audiology. I understand that not all office services and cost of an aid are covered by my insurance and that any unpaid balance not covered by my policy will be payable by me. I hereby agree to the terms of payment as discussed at the time services are rendered and in accordance with Gardner Audiology insurance policy.

Refunds from services charged on a credit card will be returned to the same credit card.

Mail/Email Authorization: I authorize Gardner Audiology to contact me via mailing, phone, text, and email addresses given above. I understand my information will never be sold; however, I may receive future promotional material from Gardner Audiology, including information from third party companies.

Treatment Authorization:

I hereby give Gardner Audiology consent for audiological treatment deemed advisable & necessary in the diagnosis and treatment of my hearing condition.

Medical Records Authorization:

I authorize the release of medical record information to 1) the above-named insurance companies 2) any physician who has participated in my health care, and 3) to any physician to whom I may subsequently be referred.

PATIENT or Legal Guardian Signature:_____ **Date:**_____

AUDIOLOGY CASE HISTORY FORM

Name: _____ Date: _____

Presenting Problem

1. What is your primary complaint about your ears or hearing? _____
2. If you have a hearing loss, how long have you noticed this? _____
3. What do you think caused your hearing problem? _____
4. Which is your worse ear (if they are different): Left/ Right
5. Do you have difficulty understanding:

   TV: Yes_____ No_____ Telephone: Yes_____ No_____ In groups: Yes _____No_____

History

1. Have you had your hearing tested before? Yes_____ No_____ If yes, when and where: _____
2. Any drainage from the ear within the past 90 days? Yes_____ No_____ Left/ Right/ Both
3. Have you experienced any dizziness, balance problems, or falls? Yes_____ No_____
4. Have you had any pain/discomfort in your ears within the past 90 days: Yes_____ No_____ Left/ Right/ Both
5. Have you ever lost hearing in one ear *suddenly*? Yes_____ No_____ Left/ Right
6. Do you have any noises or ringing in your ears? Yes_____ No_____ Left/ Right/ Both

   If yes, is it: Constant _____ Intermittent _____ When did you first notice it? _____
7. Have you received any medical or surgical treatment for hearing loss? Yes_____ No_____ Left/ Right/ Both
8. Have you ever been exposed to loud noise? Military Occupation/Job Recreational
9. Is there a history of hearing loss in your immediate family? Yes_____ No_____ Who: _____
10. Have you ever worn a hearing aid(s)? Yes _____ No _____
11. Do you currently use tobacco products? Yes_____ No_____
12. Do you have any known allergies? Yes_____ No_____ If Yes, please explain:_____
13. Medical problems (check all that apply):

    Infectious disease _____ Diabetes _____ Heart problems _____ Head injury _____ Cancer _____
    High blood pressure _____ Headache _____ Kidney failure _____ Stroke _____ Memory Loss_____
    Other (please explain): _____

Medications: _____
_____
_____
_____
_____

Comments or questions for the Audiologist:
_____
_____

Acknowledgment of Receipt of Notice of Privacy Practices

Updated October 2019

I understand that, under the Health Insurance Portability & Accountability of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information ("PHI"). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been made aware that there is a copy of Gardner Audiology's privacy practices available upon request. This form contains a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact the office to obtain a current copy of the ***Notice of Privacy Practices***.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, marketing, or health care operations. I also understand you are not required to agree to my requested restrictions, unless you are bound to abide by such restrictions.

- You can ask us to contact you in a specific way (for example, home, office or cell phone, by text or email) or to send mail to a different address. We will say "yes" to all reasonable requests.

Acknowledgment of receipt of Notice of Privacy Practices regarding protected health information
I have received Gardner Audiology's Notice of Privacy. Photocopies of this document are to be as valid as the original.

_____
Print Patient's Name

_____ _____
PATIENT or Legal Guardian **Signature** Date

Communication Preferences Regarding PHI

To assist in your hearing healthcare, it may be necessary to release your *Protected Health Information* to someone other than yourself. To whom may we communicate with?

Other Physician:_____

Spouse's Name:_____

Caregiver's Name:_____

Other Person(s):_____

_____
Print Patient's Name

_____ _____
PATIENT or Legal Guardian **Signature** Date