Hoffman Hearing Solutions

PATIENT INFORMATION

Today's Date: _____/_____/_____

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

Preferred Name (Nickname): _____

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

We'd like to be able to text you to confirm your appointment reminders. If you agree, please circle your carrier:

AT&T Verizon T-Mobile Sprint Virgin Mobile Metro PCS Cricket Other_____

Address: _____ City: _____ State: _____ Zip Code: _____

Email address: _____

Employer: _____ Occupation: _____ Employer Phone #: (___)_____

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

Emergency Contact: _____

Relationship: _____ Phone #: (____)_____

Primary Care Physician: _____ Phone #: (____)_____

Would you like us to send a copy of today's test to your physician? Yes No

Physician Name: _____

Referral Source: Tv Online Physician Referral Friend/Family Insurance

Referral Name: _____

INSURANCE INFORMATION

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 Hoffman Hearing Solutions 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 (tinnitus) in your ears?

On: Left / Right / Both Is the sound: Constant / Intermittent

Sounds Like: Ringing / Chirping / Crickets / Rushing Wind / Hissing / Steam Pipes / Other_____

Rate your tinnitus on a scale of 0-10 on a normal day(0 is fine, 10 is unbearable): _____
Yes No Does your tinnitus fluctuate? If yes, assign a number from 0-10 for the following:
Good Day_____ Bad Day_____

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

How long have you had difficulty in hearing? _____
Yes No Understanding conversations
Yes No Hearing in a crowd
Yes No Hearing by telephone
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"

Yes ____ No ____

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 Authorization of Disclosure

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The patient may revoke or change this authorization at any time with a written request.

I wish to be contacted in the following manner (check all that apply):

Home Telephone:

☐ OK to leave a message with detailed information

☐ Leave message with call-back number only

Work Telephone:

☐ OK to leave message with detailed information

☐ Leave message with call-back number only

☐ Do not call me at work

Written Communication:

☐ OK to mail to my home address

☐ OK to fax to my home fax # (____)_____

☐ Other: _____

Signature: _____ Date: _____/_____/_____

☐ Patient refused to sign

In an effort to protect your health information and the confidentiality of your healthcare, we ask that you designate below to whom the staff at Hoffman Hearing Solutions may discuss your healthcare and scheduling needs as well as billing issues that may arise.

☐ Only disclose information to myself

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Hoffman Hearing Solutions

Consent for Payment

I hereby authorize payment of medical benefits billed to my insurance to Hoffman Hearing Solutions. I have listed all health insurance plans from which I may receive benefits. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time the services are rendered. I also accept responsibility for fees that exceed the payment made by my insurance, if Hoffman Hearing Solutions does not participate with my insurance. I hereby authorize Hoffman Hearing Solutions to use and/or disclose my health information which specifically identifies me, or which can reasonably be used to identify me to carry out my treatment, payment, and healthcare operations.

I understand that while this consent is voluntary, if I refuse to sign this consent, Hoffman Hearing Solutions can refuse to treat me. I understand this authorization can only be revoked in writing, if I revoke my consent, such revocation will not affect any actions that Hoffman Hearing Solutions took before receiving my revocation.

Signature of Patient or Patient's Representative _____

Date: _____

Printed Name of Patient: _____

Relationship of representative to patient:_____