Stanford Hearing Aids

301 W 14th St. | Sioux Falls, SD 57104 | 605-338-6251
www.stanfordhearingaids.com

Financial & Insurance Policy

Since our office participates in a variety of insurance plans, we want to provide you with information to avoid any misunderstanding or disagreement concerning payment for professional services.

- Our office participates with a variety of insurance plans. It is your responsibility to:
  - Bring your insurance card to every visit.
  - Be prepared to pay your estimated portion at the time of your appointment. We accept cash, checks, Visa, MasterCard, Discover, and American Express
- If you are unable to pay for necessary medical care, you may be eligible to participate in a payment plan. It is your responsibility to inform us of this prior to your visit. We firmly believe that a good patient/provider relationship is based upon understanding and good communication. Questions about financial arrangements should be asked prior to services provided. We will be happy to refer you to our office manager prior to scheduling you for a visit.
- **Referrals:** It is your responsibility to bring any required referrals for treatment at, or prior to the visit. If you do not have the referral, your visit may be rescheduled or you may be held financially responsible.
- If the patient is a minor (younger than 18 years) and is unaccompanied by a parent or guardian, we must have a written release or permission from the parent or guardian. The parent, guardian, or unaccompanied minor is responsible for any payment due at the time of service, bringing the necessary referrals and the insurance card.
- If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company member services department. (See the number on your insurance card).

Your insurance policy is a contract between you and your insurance company. Stanford Hearing Aids is not a party in *your* contract. We can only estimate your coverage in good faith based upon the information the insurance company gives us when we call to get benefits. Please remember a “covered” service or procedure does not mean it will be covered 100%. Co-pays and deductibles are **always** factored in by your insurance company even on “covered” services. They are considered patient responsibility.

______________________________ ______/______/______

Patient Signature / Patient’s Parent / Guardian Date

INSURANCE AUTHORIZATION

I request that payment of authorized benefits be made on my behalf to Stanford Hearing Aids for services furnished to me by the provider. I authorize any holder of medical information about me to release to Stanford Hearing Aids any information needed to determine these benefits or the benefits payable for related services.

____
Initials

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize you to release to my referring and/or family doctor, such medical information as they may require or request.

____
Initials

NOTICE OF PRIVACY PRACTICES / ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have been given the opportunity to read the NOTICE OF PRIVACY PRACTICES for the office of Stanford Hearing Aids, a copy of which is available in the waiting area. I understand that a copy of this notice will be made available to me at my request.

____
Initials

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Patient Intake Form

Patient Information

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

Social Security:__________ Birthdate:__________ Gender: ☐ Male ☐ Female

Home Address:__________ Apt #:_____

City:__________ State:_____ Zip Code:_____ Email Address:__________

Cell Phone:__________ Home Phone:__________ Work Phone:__________

Marital Status : single / married / divorced / widowed / partner Spouse's Name:__________

Primary Care Physician:__________ Referring Physician:__________

Employment Status: full time / part time / retired / unemployed Occupation:__________

Are you a resident of a living facility? ☐ Yes ☐ No

If yes, what is the name of the facility?__________

Responsible Party

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

Preferred First Name:__________ Birthdate:__________ Gender: ☐ Male ☐ Female

Home Address:__________ Apt #:_____

City:__________ State:_____ Zip Code:_____ Email Address:__________

Cell Phone:__________ Home Phone:__________ Work Phone:__________

How did you hear about us?

☐ Website ☐ Newspaper ☐ Direct Mail ☐ Radio ☐ Insurance ☐ Friend / Family: __________

Other:__________

Medications

Medications *(Rx / Vitamins / Over-the-counter)*	Reason for Medication

Thank you for taking the time to fill out this release. Please sign below indicating that the information in this form has been read, understood, filled out completely & accurately to the best of your knowledge.

Signature:__________ Date:__________

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Hearing Loss Assessment

Instructions: Listed below are statements regarding different listening environments. For each statement, please rate your response 1 to 5. If you currently wear hearing devices, please answer each question according to your experience while wearing your devices.

☐ **1 = NOT APPLICABLE** through ☐ **5 = MOST APPLICABLE**

Statement					
1. When I am having a one-on-one conversation in quiet, I have difficulty understanding.	☐1	☐2	☐3	☐4	☐5
2. I have to ask people to repeat themselves.	☐1	☐2	☐3	☐4	☐5
3. I have difficulty understanding conversation when several people are talking.	☐1	☐2	☐3	☐4	☐5
4. When I'm at a restaurant, understanding speech is difficult.	☐1	☐2	☐3	☐4	☐5
5. At times I miss information when I'm listening to a lecture or sermon.	☐1	☐2	☐3	☐4	☐5
6. At times I miss information when in a large group or meeting.	☐1	☐2	☐3	☐4	☐5
7. I have trouble understanding others when in the car.	☐1	☐2	☐3	☐4	☐5
8. I have difficulty listening to the TV or radio.	☐1	☐2	☐3	☐4	☐5
9. I have difficulty on the phone:	☐1	☐2	☐3	☐4	☐5
(Do you use a cell phone?) ☐ Yes ☐ No What brand?________________					
10. I wish people would speak louder.	☐1	☐2	☐3	☐4	☐5
11. I wish people would speak clearer.	☐1	☐2	☐3	☐4	☐5
12. I have difficulty hearing women or children's voices.	☐1	☐2	☐3	☐4	☐5
13. I have difficulty hearing men's voices.	☐1	☐2	☐3	☐4	☐5
14. My hearing difficulties restrict my personal or social life.	☐1	☐2	☐3	☐4	☐5

Please list your top three situations where you would most like to hear better:

1. ________________________________

2. ________________________________

3. ________________________________

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Hearing Communication Assessment — Hearing Aids

Instructions: What is your most important consideration regarding hearing devices? Rank in order the following factors, 1 being most important and 5 as least important. **Please mark "N/A" if the item has no importance to you.**

- ☐ Cosmetics
- ☐ Understanding Speech Better
- ☐ Hearing in Noisy Environments
- ☐ Cost
- ☐ Service/Access to Care

Instructions: Do you prefer hearing devices that: **(Please check one)**

- ☐ Are completely automatic; therefore, you do not have to make adjustments to them.
- ☐ Allow you to adjust the volume and change the listening programs as you see fit.
- ☐ No preferences

Amplification History:

Have you ever worn hearing devices? ☐ No ☐ Yes If yes, which Ear: ☐ Right Ear ☐ Left Ear ☐ Both

How long have you been wearing devices? ☐ Less than 1 Year ☐ 1-10 Years ☐ More than 10 Years

What year did you buy your current devices?______________________________

Approximately how many hours a day do you wear your hearing devices?______________________________

How satisfied are you with your devices? (Check one)

☐ Very Satisfied ☐ Satisfied ☐ Neutral ☐ Dissatisfied ☐ Very Dissatisfied

Please Explain: ______________________________

____

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Medical History

Patient Name:______________________ Preferred First Name:______________ DOB:__________

Has your hearing been previously tested? ☐ Yes ☐ No

If yes, please list when and the results, if known:________________________________

Why have you decided to have your hearing tested today?________________________________

____

When did you first notice a problem with your hearing? ☐ Sudden Onset ☐ Months Ago ☐ Years Ago

Do you feel your hearing is better in one ear? ☐ Yes ☐ No **If yes, which ear?** ☐ Right Ear ☐ Left Ear

Have you ever experienced any of the following major medical problems? (Please list approx. date of diagnosis)

- ☐ Diabetes I or II
- ☐ Arthritis
- ☐ Fatigue
- ☐ Dementia/Alzheimers
- ☐ High Blood Pressure
- ☐ Meningitis
- ☐ Blood Disorder/Thinner
- ☐ Cancer: ______________________
- ☐ Stroke
- ☐ Scarlett Fever
- ☐ Head/Neck Injury
- ☐ TMJ
- ☐ Heart Problems
- ☐ Visual Difficulties/Disturbances

List all significant medical history if it was not mentioned above:________________________________

Regarding your ears & hearing, are you currently experiencing any of the following? *If no, leave section blank.*

Tinnitus/Ringing in the Ears — ☐ Right Ear ☐ Left Ear

How long have you experienced it or when did it start?______________ Is it constant or does it come and go? ________

Do you notice it more during the day or night? ☐ Day ☐ Night

Please describe the sound: **Pitch High / Low / Roaring / Thumping / Crickets / Cicadas?** ______________________

Falling Down — How many falls in the past 12 months?________ Have you been injured: ☐ Yes ☐ No

History of Ear Infections — ☐ Right Ear ☐ Left Ear

☐ **Itchy Ears** ☐ Right Ear ☐ Left Ear ☐ **Previous Ear Surgery** ☐ Right Ear ☐ Left Ear ☐ **Ear Deformity** ☐ Right Ear ☐ Left Ear

☐ **Ear Pain** ☐ Right Ear ☐ Left Ear ☐ **Ear Pressure/Fullness** ☐ Right Ear ☐ Left Ear ☐ **Ear Drainage** ☐ Right Ear ☐ Left Ear

What for & when?____

If there are other medical experiences or symptoms regarding your ears that is not mentioned above please provide this information here:

____

Family History of Hearing Loss? ☐ Yes ☐ No

Who is the family member(s) and approximate age of hearing loss onset?________________________________

____

Dizziness — ☐ Unsteady/Balance Struggles ☐ Lightheadedness ☐ True Spinning Sensations

Is it accompanied by: ☐ Nausea ☐ Ringing/Noises in Ear(s) ☐ Hearing Loss ☐ Other

Please describe when it happens, how often, how long and can you do anything to alleviate the symptoms:

____

History of Noise Exposure — Did you wear protection when exposed? ☐ Yes ☐ No

Please list the types of noise:____