Stanford Hearing Aids

In-Take FORM

StanfordHearingAids.com

PERSONAL INFORMATION

Name _____ Nickname _____ Date of Birth _____

Address _____ Marital Status M Sex M

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Email Address _____

Communication Preference (check one or both) ☐ **Email** ☐ **Text**

Name of person who came with you _____ Relation to You? _____

MEDICAL INFORMATION (IN ORDER TO PROCESS CLAIMS)

Personal Physician _____ Phone _____

Address _____

Name of Facility _____

Primary Insurance _____

Name of Insurance Policy Holder _____

Policy Holder's Date of Birth _____

Please present insurance card if you would like us to keep a copy on file for future testing.

OTHER INFORMATION (DO YOU HAVE ANY OF THE FOLLOWING?)

(Please check Yes or No for each question)

Sudden or rapid hearing loss in the past 90 days?	**Yes** ☐	**No** ☐
Acute or recurring dizziness?	**Yes** ☐	**No** ☐
Ringing in the ears?	**Yes** ☐	**No** ☐
Previous ear infections?	**Yes** ☐	**No** ☐
Active drainage from ears?	**Yes** ☐	**No** ☐
Have you had ear surgery?	**Yes** ☐	**No** ☐
Deformity of the ear?	**Yes** ☐	**No** ☐
History of radiation or chemotherapy?	**Yes** ☐	**No** ☐
Are you Diabetic?	**Yes** ☐	**No** ☐

REFERRAL INFORMATION

Who can we thank for your referral? _____

I authorize this office to release any information necessary to my personal/referring physician and insurance company. Should there be a charge, I hereby authorize payment directly to the audiologist/hearing instrument specialist for services provided. I understand that if I have an HMO I am ultimately responsible for obtaining proper referral, and any portion that may not be covered (in or out of network) or paid by my insurance is my responsibility.

PATIENT SIGNATURE _____ **DATE** _____

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Hearing HISTORY

NAME:_____DATE:_____

MEDICAL HISTORY

Will this be your first hearing test? ..... Y

Location of Last Test _____

Have you had ear surgery? ..... Y

Type? _____

Have you ever found it necessary to have a doctor remove wax from your ears? ..... Y

In which ear is your hearing the worst? L

Are you taking any prescription medication? ..... Y

Type? _____

Do you have any medical problems? ..... Y

Type? _____

HEARING

Have you noticed that people seem to mumble? ..... Y

Do you sometimes hear words, but don't always understand them? ..... Y

Do you find it difficult to hear in noisy places? ..... Y

Are you often asking others to speak up or repeat themselves? ..... Y

Do others complain that you play the TV too loudly? ..... Y

If a hearing loss is discovered, are you ready for help? ..... Y

List the top three situations where you would most like to hear better:

_____

_____

_____

On a scale of 1 to 10, how much does your difficulty hearing annoy, bother or upset you?

1=NOT AT ALL | 10= A LOT 10

HEARING AIDS

Do you have or have you ever worn a hearing instrument? ..... Y

Brand _____ *How old? 1-2yrs | 3-4yrs | 5+yrs* N/A

On a scale of 1 to 10, how ready are you for hearing aids (if recommended)?

1=NOT READY | 10=VERY READY 10

Regarding hearing aids, rate the following from **1** (most important) to **4** (least important) in order of importance.

_____ *Size of Instrument* _____ *Improved Hearing* _____*Cost* _____*Ease of Operation*

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HIPAA SIGNATURE PAGE

StanfordHearingAids.com

Date: _____

Patient Name: _____ DOB: _____

Notice of Privacy Practices

_____ (Patient Initials) I acknowledge that I have received or been offered the practice's Notice of Privacy Practices, which describes the ways in which the practice may use my healthcare information for treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact Privacy Officer designated on the notice if I have questions or a complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

Disclosure to Friends and/or Family Members

_____ (Patient Initials) I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the individuals listed below.

NAME	RELATIONSHIP	CONTACT NUMBER

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 agreements 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 the 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 _____ **DATE** _____
(or Patient's Parent/Guardian when applicable)

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 information needed to determine these benefits or the benefits payable for related services.

_____
Initials

AUTHORIZATION TO RELEASE MEDICAL RECORDS
I herby 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

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Stanford Hearing Aids is required by law to maintain the privacy of **Protected Health Information ("PHI")** and to provide you with this Notice of our legal duties and privacy practices with respect to PHI. PHI is information that may identify you and that relates to your past, present or future physical health condition and related health care services. This Notice describes how we may use and disclose your PHI to carry out treatment, payment, or health care operations and for other specified purposes that are permitted or required by law. This Notice also describes your rights with respect to your PHI.

Your Health Information Rights

You have the following rights with respect to PHI about you:

- You may request a copy of this Notice at any time. To obtain a paper copy, contact us at 301 W. 14th Street, Sioux Falls, SD 57104.
- You have the right to request additional restrictions on our use or disclosure of your PHI by sending a written request to our Privacy Officer. We are not required to comply with those additional restrictions.
- You have the right to inspect our PHI about you by sending a written request to our Privacy Officer. We may charge a fee for the copying and mailing of your PHI.
- If you feel that the PHI we maintain about you is incomplete or incorrect, you may request that we amend it by sending a written request to our Privacy Officer. If we deny your request, you have the right to file a statement of disagreement.
- You have the right to receive an accounting of the disclosures we have made about your PHI after April 14, 2003 for purposes other than treatment, payment or health care operations by sending a written request to our Privacy Officer. The request must specify a time period that does not exceed six years. This accounting will exclude disclosures made to you or disclosures you authorize.

How We May Use and Disclose PHI

The following are descriptions and examples of ways we may use and disclose PHI:

- We may use or disclose your PHI in order to treat you, obtain payment for services provided to you and conduct our health care operations activities.
- We may use or disclose your PHI to your other health care providers when such PHI is required for them to treat you, receive payment for services they render to you, or conduct health care operations activities.
- We may disclose your PHI to a family member, other relative, a close friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure.
- We may disclose your PHI to a health oversight agency that oversees the health care system and is charged with the responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.
- We may disclose your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.
- We may disclose your PHI to the Police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury of administrative subpoena.
- We may disclose your PHI to a coroner or medical examiner as authorized by law.

- We may disclose your PHI without your consent or authorization if an Institutional Review Board/Privacy Board approves a waiver of authorization for disclosure.
- We may disclose your PHI to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.
- We may disclose your PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances required by law.
- We may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to Worker's Compensation or other similar programs.
- We may use and disclose PHI when required to do so by any other law not already referred to in the preceding categories.

Use and Disclosures Requiring Your Written Authorization

The following are examples of the use and disclosure of your PHI that would require your written authorization:

- Disclosures to a life insurance company for coverage purposes.
- Disclosures to an employer for a pre-employment test.
- Disclosures to third parties for marketing purposes.

The written authorization must be in plain language, contain speci c instructions about the PHI to be used or disclosed, and identify the person(s) receiving the PHI. You may revoke your authorization at any time, except to the extent that we have acted in reliance upon it, by delivering a written revocation statement to our Privacy Officer.

Effective Date and Duration of This Notice

This notice became effective on April 14, 2003. We may change the terms of this notice at any time. If we change this Notice, we may make the new Notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised Notice in the waiting areas of our practice. You may obtain a copy of any revised Notice by submitting a written request to our Privacy Officer.