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Patient Registration

Revised 02/18/2020

Please complete this registration packet and bring to your appointment along with insurance cards and photo ID. Referrals and co-payments are due at the time of your visit.

First Name: ______________________________ MI: ___ Last Name: _________________________________
Date of Birth: ____________________ Nickname/Preferred Name: ___________________________________
Parent/Guardian Full Name: ____
Social Security #: ______________________ (not applicable under 18) Male: ☐ Female: ☐
Address: ____
City: ____ State: _________ Zip Code: _______________
Home Phone: __________________________________ Cell Phone: ___________________________________
Email Address: ____

Whom may we thank for referring you? ____

Patient's Profession: ____
Patient's Employer: ____ Phone: _________________________
Employer Address: ____

Emergency Contact: ____ Relationship: ______________________
Phone: _______________________________________ Alternate Phone: ______________________________

Person Responsible for Payment: ____
Driver's License #: ____ SS#: ___________________________

ALL INFO REQUIRED IN ADDITION TO COPY OF CARD(S)
Primary Insurance: ___________________ ID #: ________________________ Group #: ______________________
Secondary Insurance: __________________ ID #: ________________________ Group #: ________________
Is the patient the insurance subscriber? ( ) YES – Skip to physician info ( ) NO – Please complete info below:
Subscriber's Name:_______________________________________ Relationship: ____________________
Subscriber's DOB: _________________________________ SS#: ____
Address if different from patient: ____
Subscriber's Employer: ____
Employer Address: ____
City: ____ State: _________ Zip Code: _______________

Primary Care Physician: ____
Address: ____
Phone: ____ FAX: ______________________________________
Other relevant physicians (i.e. ENT, Neurologist): ____
Do we have your permission to send a report to the physician(s) listed above (recommended): ☐ Yes ☐ No

PLEASE READ, COMPLETE, AND SIGN THE PRIVACY AND FINANCIAL POLICY FORMS INCLUDED IN THIS PACKET

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Audiology Associates, Inc. Financial Policy

Thank you for choosing us as your hearing healthcare provider. We are committed to your treatment being successful. The following is a statement of our financial policy, which we require you to read and sign prior to any evaluation or treatment. Please let us know if you have any questions regarding this policy.

COPAYMENTS are due at the time of visit. MEDICARE requires a physician's order for all audiology services. REFERRALS are due at the time of visit. We accept CASH, CHECKS, VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS. MISSED or cancelled appointments without 24-hour notification will incur a $25 fee. All REFUNDS are issued via check.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. **Please make sure that you understand your insurance policy. Please be aware that some and perhaps all of the services rendered may be a non-covered benefit under your plan's policy and therefor will be your responsibility. All co-pays, deductibles, and co-insurances that you have will be billed to you as indicated by your insurance company.** We are participating providers with most insurance carriers. If your insurance company ahs not paid your claim within 60 days, this office will notify you. If you belong to an HMO, MCO, or POS, it is your responsibility to obtain a referral from your primary care physician's office. If you are seen without a referral, payment will be due at the time of service.

Usual and Customary

Our practice is committed to providing the best hearing healthcare for our patients, and we charge what is usual and customary for our area. For insurance carriers not contracted with us, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Past Due Accounts

Audiology Associates, LLC will file your claim with your insurance, if we participate with your insurance; otherwise, payment is required in full for all services at the time they are rendered. You are responsible for all charges not covered by your insurance company. All co-payments and deductibles are to be paid in full within 90 days of your first statement being generated. Unpaid balances after 90 days will incur a $5.00 statement fee. Unpaid balances that are turned over to an external collection agency will incur a fee of 25% of the amount due on the account. You are responsible for all legal fees if your account is turned over to a lawyer for collection. Your signature below signifies your understanding and willingness to comply with this policy.

Check Return Policy

Returned check may be assessed up to a $20.00 service charge (per resubmit to bank).

I authorize the release of information to primary/secondary insurance companies.
I understand that I am responsible for my bill (Both parent(s) and legal guardian(s) are responsible for the minor's bill).
I authorize payment directly to Audiology associates, Inc.
I permit a copy of this authorization to be used in place of an original.
I have read the policy above and understand and agree to terms as list.

_______________________________________ ___________________________
Signature of Responsible Party Date

_______________________________________ ____________________________
Signature of Co-Responsible Party Date

Audiology Associates, Inc.
Health Information Privacy and Affordability Act (HIPAA) Packet

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

- This Notice informs me how Audiology Associates, Inc. will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Audiology Associates, Inc. may use and share my health information for other than treatment, payment, and health care operations.
- Audiology Associates, Inc. will also use and share my health information as required/permitted by law.
- I acknowledge that I received a copy of Audiology Associates Inc.'s Notice of Privacy Practices.
- I further acknowledge that a copy of the current notice will be posted in the reception area, the website (if applicable) and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment if amended.

AUTHORIZATION TO USE AND DISCLOSURE OF HEALTH INFORMATION

I request and authorize Audiology Associates Inc. to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information in not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

____ I consent to mailings of birthday cards and/or reminder cards (initial if yes).

PLEASE INITIAL NEXT TO ONE OPTION BELOW:

_____ OPTION 1:	____ OPTION 2:
I consent to Audiology Associates Inc. releasing protected health information as detailed below. Please list names of **FAMILY or PERSONAL REPRESENTATIVES** we may disclose information to in the event that you are unable to contact us directly for any related Audiological questions or needs pertaining to you care and/or financial issues. ______________________________________ ______________________________________ ______________________________________	I **prohibit** Audiology Associates from using and disclosing medical information to any person or entity other than required by HIPAA regulations. If this option is initialed, your doctor will not receive a copy of your report and we may not discuss your care with any family members or personal representatives.

AUTHORIZATION AND RELEASE FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR MARKETING

______ Please initial here only if you authorize Audiology Associates, Inc. to use or disclose your protected health information for marketing related products or services. I understand that Audiology Associates, Inc. or its business associates may receive financial remuneration in exchange for making the marketing communication on behalf of the third party whose product or service is being described. I understand that if the person/organization authorized to receive and use the information is not a health plan of health care provider, the disclosed information may no longer be protected by federal privacy regulations.

I authorize Audiology Associates Inc. to use and disclose my protected health information as set forth above. I understand that this authorization is voluntary and that Audiology Associates Inc. cannot condition my treatment, service, etc., on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship. This authorization will expire (1) one year from the date it is signed.

____ ________________
Printed name of patient of personal representative Date of Birth

____ _________________
Signature of patient or personal representative Date Signed

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. I understand that revocation of this authorization will not affect any action the above-named entity took in reliance on those authorization before the above-named entity received my written notice of revocation. I may revoke this authorization at any time by signing the revocation section of mu copy of this form and returning it to Audiology associates Inc at the address listed below.

Only sign the revocation section below if you wish to revoke all prior authorizations regarding the use and disclosure of your health information:

Revocation Signature: ____ Date: ______________________

Audiology Associates, Inc.
3615 E. Joppa Road, Suite 200
Parkville, MD 21234

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Adult History Form

Revised 03/09/2020

Patient Name: ___________________________ DOB: ___________ Today's Date: ___________

1. What brings you in to see us today? ____
2. How long have you had difficulty hearing, if any? ____
3. Better ear? ☐ Right ☐ Left ☐ Same
4. Pain from ears? ☐ Yes Which ear? _______ How long? _______ ☐ No
5. Any blocked feeling? ☐ Yes Which ear? _______ How long? _______ ☐ No
6. Ringing or noises in ears? ☐ Yes Which ear? _______ How long? _______ ☐ No

   ** If yes, please complete the last page of this packet (TRQ/PHQ-2).
7. Have you worn hearing aids? ☐ Yes Which ear? _______ How long? _______ ☐ No
8. Do you have any dizziness? ☐ Yes How long? ____________________ ☐ No
9. Have you fallen within the past year or are you at risk of falling? ☐ Yes ☐ No
10. History of ear surgeries/tubes? ☐ Yes Which ear? _____ Explain: __________________ ☐ No
11. Family history of hearing loss? ☐ Yes Who? ________________ Age-related?: _____ ☐ No
12. Worked around or exposed to loud noises? ☐ Yes Where/Number of years? ________ ☐ No
13. Facial numbness? ☐ Yes ☐ No
14. Have you had a recent cold or influenza? ☐ Yes When? _____________ ☐ No
15. A) Do you have sinus problems? ☐ Yes ☐ No 15. B) Do you have allergy problems? ☐ Yes ☐ No
16. A) History of depression? ☐ Yes ☐ No 16. B) Do you have a pacemaker? ☐ Yes ☐ No
17. **Please check if you have any of these health issues:**

    ☐ Diabetes ☐ Heart ☐ Circulatory ☐ Head Injury ☐ Head or neck surgery ☐ Radiation/Chemotherapy

    ☐ Memory Loss or Cognitive Issues ☐ Kidney Disease

    ☐ **Other**____
18. Known allergies? Please list: ____
19. Last surgery date? ______________ Procedure: ____
20. Last hospitalization date? ____________Reason:____
21. Use of alcohol? ☐ Yes ☐ No
22. **Use of tobacco one or more times in the last 24 months (cigarettes, cigars, smokeless tobacco)? ☐ Yes ☐ No**
23. Additional comments to discuss with the audiologist: ____
24. **Do you take any medications or vitamins? ☐ Yes – List below; Continue on back if needed ☐ No**

Medication Name	**Dosage**	**Frequency**	**Route** (i.e. oral)	**For what medical condition?**

Hearing Health Quick Test

1. Do you find it difficult to follow a conversation in a noisy restaurant or crowded room?
   ☐ Yes ☐ No ☐ Sometimes

2. Do you sometimes feel that people are mumbling or not speaking clearly?
   ☐ Yes ☐ No ☐ Sometimes

3. Do you experience difficulty following dialog in the theater?
   ☐ Yes ☐ No ☐ Sometimes

4. Do you sometimes find it difficult to understand a speaker at a public meeting or a religious service?
   ☐ Yes ☐ No ☐ Sometimes

5. Do you find yourself asking people to speak up or repeat themselves?
   ☐ Yes ☐ No ☐ Sometimes

6. Do you find men's voices easier to understand than women's?
   ☐ Yes ☐ No ☐ Sometimes

7. Do you experience difficulty understanding soft or whispered speech?
   ☐ Yes ☐ No ☐ Sometimes

8. Do you have difficulty understanding speech on the telephone?
   ☐ Yes ☐ No ☐ Sometimes

9. Does a hearing problem cause you to feel embarrassed when meeting new people?
   ☐ Yes ☐ No ☐ Sometimes

10. Do you feel handicapped by a hearing problem?
    ☐ Yes ☐ No ☐ Sometimes

11. Does a hearing problem cause you to visit friends, relatives, or neighbors less often than you would like?
    ☐ Yes ☐ No ☐ Sometimes

12. Do you experience ringing or noises in your ears?
    ☐ Yes ☐ No ☐ Sometimes

13. Do you hear better with one ear than the other?
    ☐ Yes ☐ No ☐ Sometimes

14. Have you had any significant noise exposure during work, recreation, or military service?
    ☐ Yes ☐ No

15. Have any of your relatives (by birth) had a hearing loss?
    ☐ Yes ☐ No

Scoring

2 points for Yes

1 point for Sometimes

0 points for No

Scores of 3 or more: May mean that you have a hearing problem.
Scores of 6 or more: Strongly suggest that a hearing check is warranted.

If you think you may have a hearing loss, visit **www.HowsYourHearing.org** and click on the "Find an Audiologist" link to locate and set up an appointment with an audiologist in your area to get your hearing checked.

AMERICAN ACADEMY OF AUDIOLOGY ™

Tinnitus Reaction Questionnaire

Please complete this page if you experience ringing, buzzing, or other sounds in your ears.

Patient Name: ____________________________ Date Completed: _______________________

This questionnaire is designed to find out what sort of effects tinnitus has had on your lifestyle and general well-being. Some of the effects below may apply to you, some may not. Please answer ALL questions by circling the number that BEST REFLECTS how your tinnitus has affected you OVER THE PAST WEEK.

	Not at all	**A little of the time**	**Some of the time**	**A good deal of the time**	**Almost all of the time**
My tinnitus has made me unhappy.	0	1	2	3	4
My tinnitus has made me feel tense.	0	1	2	3	4
My tinnitus has made me feel irritable.	0	1	2	3	4
My tinnitus has made me feel angry.	0	1	2	3	4
My tinnitus has led me to cry.	0	1	2	3	4
My tinnitus has led me to avoid quiet situations.	0	1	2	3	4
My tinnitus has made me feel less interested in going out.	0	1	2	3	4
My tinnitus has made me feel depressed.	0	1	2	3	4
My tinnitus has made me feel annoyed.	0	1	2	3	4
My tinnitus has made me feel confused.	0	1	2	3	4
My tinnitus has "driven me crazy."	0	1	2	3	4
My tinnitus has interfered with the enjoyment of my life.	0	1	2	3	4
My tinnitus has made it hard for me to concentrate.	0	1	2	3	4
My tinnitus has made I hard for me to relax.	0	1	2	3	4
My tinnitus has made me feel distressed.	0	1	2	3	4
My tinnitus has made me feeL helpless.	0	1	2	3	4
My tinnitus has made me feel frustrated with things.	0	1	2	3	4
My tinnitus has interfered with my ability to work.	0	1	2	3	4
My tinnitus has led me to despair.	0	1	2	3	4
My tinnitus has led me to avoid noisy situations.	0	1	2	3	4
My tinnitus has led me to avoid social situations.	0	1	2	3	4
My tinnitus has led me to feel hopeless about the future.	0	1	2	3	4
My tinnitus has interfered with my sleep.	0	1	2	3	4
My tinnitus has led me to think about suicide.	0	1	2	3	4
My tinnitus has made me feel panicky.	0	1	2	3	4
My tinnitus has made me feel tormented.	0	1	2	3	4
TOTAL					

Patient Health Questionnaire (PHQ-2)

Over the past 2 weeks, how often have you been bothered by the following problems:

	Not at all	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3