Patient History

Patient Name:____ Today's Date:________________________

Referring Physician: ____Date of Birth: _____________________________

What kind of problem is the patient being seen for today? (Symptoms) ____

____

How did you hear about our office? ____
(yellow pages, radio, referral by friend/family, newspaper, internet, etc….)

Has the patient had this problem before? **YES** **NO** How long ago? __________________

Does the patient have a history of illness or injury? **YES** **NO**

Check all that apply:

_____ Family Hearing Loss _____ Excessive noise exposure _____ High Blood Pressure

_____ Dizziness _____ Frequent ear infections _____ Cancer

_____ Noises in the ear(s) _____ Trauma to the head _____ Diabetes

_____Ear Surgery _____ Arthritis

_____ Other – List: ____

Is the patient currently on any medications? (Please List) ____

____

Is there a family history of major illness or disease? **YES** **NO**

If yes, please list illness or disease:____

Please Circle Smoking History: Non-Smoker Current Smoker Former Smoker

Fill out the section below if the patient is under 10 years of age:

Does the patient have a history of: (Check all that apply)

_____Prematurity _____ Frequent Ear Infections

_____ Low Birth Weight _____Measles, Mumps or Meningitis

_____ Cleft Lip or Palate _____ Other: ____

Do you have any concerns about the child's speech and language development? ____

Patient Information Form

Please complete all information. If not applicable, write N/A. Present all insurance cards to the receptionist.

PATIENT INFORMATION (Please Print)

_______________________________ , _______________________________ , ____ _______ ___________________ _________________________

Last Name First Name Mi. Age Date of Birth Social Security No.

____ ________________________________ ______ ____________ _______________________

Address City State Zip Home Phone Number

Circle Gender: Male Female **Circle Patient's Marital Status:** *Single* *Married* *Divorced* *Widowed*

Emergency Contact, Relationship and Phone Number: ____
(Relative not living in your home)

Referring Physician Name and Phone Number: ____

Patient Employer's Name and Phone Number: ____

Email Address of Patient or Guardian ____

Circle the Primary (#1) Insurance Policy Holder : *Self* *Spouse* *Parent* *Other Relationship*:_________________________

____ ________________________ ____

Name of Policy Holder *(if other than self)* Date of Birth Social Security Number

Circle the Secondary (#2) Insurance Policy Holder : *Self* *Spouse* *Parent* *Other Relationship*:________________________

____ ________________________ ____

Name of Policy Holder *(if other than self)* Date of Birth Social Security Number

COMPLETE THIS SECTION IF PATIENT IS A MINOR, STUDENT OR FACILITY DEPENDANT

Responsible Party Name ____ (____Father, ____Mother, ____Step Parent, ____ Other)

____________________________________ ______________________________ _____________ ____________________ _____________________

Mother (or Legal Guardian) Name Address *(if different from above)* Date of Birth Social Security Number Contact Phone Number

____________________________________ _____________________________ _____________ ____________________ _____________________

Father (or Legal Guardian) Name Address *(if different from above)* Date of Birth Social Security Number Contact Phone Number

____ ____

Name of Mother's Employer & Phone Number Name of Father's Employer & Phone Number

____

☆ ***PARENT OR GUARDIAN'S SIGNATURE/AUTHORIZATION TO TREAT A MINOR***

Center for Audiology, P.C. Financial Responsibility and HIPAA Agreement

We strive to provide high quality, cost effective care to our patients. Our first priority is to you, our patient. As we are sure you understand, to continue providing care we must receive prompt payment for the services rendered. Your assistance in seeing that your account is kept current is appreciated. Please read this agreement, sign and date.

- This office will accept the following methods of payment for services rendered: **Visa/Discover/MasterCard/American Express/Cash/Debit Card/Cashier's Check/Money Order/Care Credit/Wells Fargo/Personal Check**
- Responsible parties without insurance coverage agree to pay for services in full at time of service.
- This office accepts third party payment from Workers' Compensation Plans with written authorization prior to services.
- It is our policy to submit any insufficient funds to the appropriate legal authorities. A $25.00 charge will be added to your account for each check returned.
- Responsible party agrees to pay all costs of collection including attorney fees, collection fees, court costs, skip tracing costs and contingent fees to collection agencies. Past due balances will be forwarded to the collection agency immediately upon default of account.
- In cases of divorced parents, the parent bringing the child will be deemed responsible for payment. We will not be involved with personal issues between divorced/separated spouses. It is your responsibility to coordinate payment for services rendered. We will not allow another party responsible without their written consent.
- The most common misconception concerning insurance is that your policy will cover the total cost of service fees charged. Insurance is designed to reduce your out of pocket cost, but usually will not eliminate it entirely.
- Co-payments are due at the time of service. Co-insurance and deductibles are determined by your insurance company are due upon receipt of a billing statement after insurance has processed.
- Insurances are filed as a courtesy to you and does not relieve you of your financial responsibility. If coverage is unable to be verified, you are responsible for all charges incurred.
- All insurance information must be provided and verified before services are rendered.
- It is the patient responsibility to know if their insurance plan requires a referral from their primary doctor.
- Center for Audiology utilizes The Billing Alliance for insurance billing. The Billing Alliance will send no more than THREE (3) billing statements per date of service. It is your responsibility to keep your account current and to update us with address or insurance changes as they occur. All account balances must be paid within THIRTY (30) days from the date on the statement.
- Responsible party understands that Center for Audiology has authorization to release any or all medical information to all my insurance carriers if requested for the processing of claims.
- Responsible party authorizes the payment of any insurance or other medical benefits directly to Center for Audiology.

THE UNDERSIGNED CERTIFIES THAT THIS AGREEMENT HAS BEEN READ, UNDERSTOOD, AND AGREED UPON. ANY QUESTIONS CONCERNING THE FOREGOING HAVE BEEN DISCUSSED BEFORE SIGNING. THE UNDERSIGNED IS EITHER THE PATIENT OR DULY AUTHORIZED REPRESENTATIVE OF THE PATIENT. THE UNDERSIGNED ACKNOWLEDGES ACCESS TO A COPY OF THE CENTER FOR AUDIOLOGY PRIVACY PRACTICES AND BY SIGNING BELOW, ACKNOWLEDGES THE TERMS AND CONDITIONS THEREIN.

YES	NO	
		Permission for Phone Calls & Phone Messages - Includes all numbers listed by you on the patient information form, answering machines, voicemails, and messages left with the recipient of a call.
		Permission for Special Mailings - Center for Audiology newsletters, special offers & event notifications. ***No*** *personal information will be sold to another entity.*

____

Patient Name **PRINT**

____

Patient or Responsible Person **SIGNATURE** (Guarantor) Date Relationship to Patient

____

Responsible Person **PRINT** (Guarantor)

I have witnessed the patient or guarantor review this agreement and he/she appears to fully understand these conditions.

____

Signature of Center for Audiology Registering Personnel

CENTER FOR AUDIOLOGY PERSONAL REPRESENTATIVE FORM

______________________	______________________	______________________
Name of Patient	**Patient Date of Birth**	**Patient Contact Phone #**

You have the right to appoint a family member or friend access to, a portion, or all of your protected health information. This action does not restrict your rights to your own personal health information; it merely allows someone of your choosing to have access as well. You do not have to appoint a representative.

I hereby authorize Center for Audiology to disclose my protected health information (as described below) to the individual(s) named below. I understand that the protected health information released to the individual(s) named below may be further disclosed by the recipient and no longer protected by Federal law.

CHOOSE AND INITIAL ***ONE*** STATEMENT:

_______ (initial) I hereby authorize Center for Audiology to disclose ***ALL*** of my protected health information to my personal representative. This information will include clinical information about my care, billing information related to my health insurance coverage and payment activity for services rendered by Center for Audiology. The representative may also make demographic changes to my account. By choosing this option, I understand that my personal representative will have the same access as I do to my medical records and health data.

_______ (initial) I hereby authorize Center for Audiology to disclose ***ONLY*** the protected health information listed below. By choosing this option, I understand that my personal representative will only have access to the specific portion(s) of my medical records that I choose: ____

(Example: billing information only, test results only, treatment notes, etc…)

_______ (initial) I ***DO NOT*** wish to assign a personal representative at this time.

Representative's Full Name	**Representative's Birthdate**	**Representative's Contact Phone #**
1.) ______________________	______________	______________
2.) ______________________	______________	______________
3.) ______________________	______________	______________

I understand that except to the extent that action has been taken based on my authorization, I may revoke this authorization at any time by written notification to Center for Audiology, Attn: Privacy Officer
Center for Audiology
1740 Memorial Drive, Suite 1
Clarksville, TN 37043

Center for Audiology will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on my provision of this authorization unless the authorization was for research related treatment and information disclosure, or the treatment is solely for the purpose of disclosing to another individual or business. I understand that I may refuse to sign this authorization and that Center for Audiology will not retaliate against me if I refuse to do so. I understand I have the right to receive a copy of this authorization.
I understand that Center for Audiology reserves the right to request proof of identity of representatives for verification purposes.

Signature of Patient, Guardian or Power of Attorney____

Printed Name of Patient, Guardian or Power of Attorney ______________________________

Date ___________________

Center for Audiology
1740 Memorial Drive, Suite 1
Clarksville, TN 37043
Phone (931) 645-3937
Fax (931) 645-1043
www.clarksvillecenterforaudiology.com

NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices is required by the Privacy Regulations stemming from the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

This practice is determined to protect the privacy of your medical information. As we provide service to you, we create and store health information (a medical record) that identifies you. It is often necessary to share or disclose this health information in order to provide treatment for you, to obtain payment, and to conduct healthcare operations in our office.

This Notice of Privacy Practices requires us to:

1. Keep your medical records private and provide you with this notice.
2. Update our privacy practices and the terms of this notice at any time, ensuring our notice is effective, even for information recently obtained.

We reserve the right to make an important change in our privacy practices and change this notice to that effect. You may contact us to request a new copy of our notice and we will make the new notice available upon request.

The following are descriptions of the different circumstances that may require our practice to use or disclose your medical information.

1. Sharing medical data with another provider who is responsible for your care (physicians, audiologists, nurses, other healthcare professionals, technicians, students in healthcare, or any other people who take care of you), making referrals, and/or placing lab/prescription orders.
2. Sharing with your health insurance plan information about a treatment you received at our practice when filing a claim for reimbursement or determination of benefits.
3. To business associates to perform functions on our practice's behalf, if the business associate has signed an agreement to protect the confidentiality of the information.
4. Sharing information about your condition(s), location, and/or death with family member(s) or your personal representative(s). Prior permission from you will be obtained unless in case of emergency. If we are unable to obtain permission, we will share only the health information directly necessary for your health care.
5. Provide treatment communication concerning treatment alternatives or other health-related products or services, unless we or a business associate receive financial remuneration in exchange for the communication, in which case we must receive your written authorization, unless the communication is made face-to-face or involves gifts of nominal value.
6. Disclosing medical information to a medical examiner to identify a deceased person or to determine the cause of death, or for tissue donations.
7. Medical information may be disclosed if you are military personnel, either active or veteran, and if required by the appropriate authorities.
8. Sharing medical data with the public health and/or law enforcement official whose job it is to prevent or control disease, injury or disability.
9. Sharing medical data with a representative from the Food and Drug Administration for the purpose of reporting adverse effects stemming from defective products, etc.
10. Medical information may be disclosed when necessary to comply with workers' compensation.
11. Medical information may be disclosed in response to a court and/or administrative order in a lawsuit or similar proceeding.
12. In order to contact you for fundraising activities supported by our practice. You have the right to opt out of receiving these communications by signing a Privacy Permission Form.
13. For marketing purposes for which our practice or our business associates may receive remuneration, for a disclosure that constitutes a sale of protected health information, and in all other situations not described in this policy, your written authorization will be obtained before our practice will use or disclose your health information to third parties outside our practice. You have the right to revoke such authorization by providing our practice with a written request to revoke the specific authorization or by signing a Privacy Permission Form.
14. If a use of disclosure is required by law, the disclosure will be made in compliance with the law and will be limited to such requirements. State and federal laws may be more stringent and may prohibit certain uses and disclosures identified above. When another law is more stringent than HIPAA, we will follow more stringent requirements.

You have individual rights as part of the Notice of Privacy Practices. As a patient of an Audigy Certified practice, you have the right to:

1. Request that our practice restrict uses and disclosures of your health information. However, we are not required to agree to the requested restriction unless you are requesting a restriction on the use and disclosure of your protected health information to a health plan for payment or healthcare operations and such information pertains to a healthcare item or service which you paid for in full or out of pocket. These requests should be made in writing to the address given in this privacy notice. In your request, you must tell us (a) what information you want to limit; (b) whether you want to limit our use, disclosure, or both; (c) to whom you want the limits to apply.
2. Be notified upon a breach of any of your unsecured protected health information.
3. Request that we communicate with you regarding your confidential medical information by different means or at different locations. This request must be made to our practice in writing.
4. Request photocopies of your medical records on file and/or a copy of this Notice of Privacy Practices. If you need a photocopy, please notify the receptionist.
5. Request a change to your health information if you think it is incomplete or inaccurate. However, if the audiologist, hearing care professional, or office personnel believe the patient's health information is complete and accurate, he/she can refuse to make the requested changes. This request must be made in writing to your Audigy Certified practice.
6. Receive a list of all the times your medical information has been shared by our office or our business associates for six years prior to the request date, other than treatment, payment, healthcare operations, and/or other specified exceptions.
7. Request a paper copy if you have received this Notice of Privacy Practices electronically. This request must be made in writing to your Audigy Certified practice.

This notice is effective as of August 2013.

According to HIPAA regulations, you have the right to restrict the uses or disclosures of your information made for purposes of treatment, payment, and/or healthcare operations.

- Treatment is the provision, coordination, or management or hearing health care. For example, we may use and disclose your information to consult with a third party or to refer you to other healthcare providers. We will get your written consent prior to making disclosures outside our practice for treatment purposes, except in emergencies.
- Payment includes the activities necessary to obtain reimbursement for the provision of hearing healthcare. For example, we may need to give your health plan information about treatment you receive at our practice so your health plan will pay us or reimburse you for the treatment. We will get your written consent prior to making disclosures for payment purposes.
- Healthcare operations include the activities necessary for our practice to run its business operations. For example, we may use your information to review treatment and services and to evaluate the performance of our staff.

If you have any questions regarding our privacy practices or think we may have violated your privacy rights, please contact us at:

Center for Audiology
1740 Memorial Drive, Suite 1
Clarksville, TN 37043

If your concern is not resolved, you may also submit a written complaint to the U.S. Department of Health and Human Services. If you choose to file a complaint, we will not retaliate in any way.

Audigy Certified Professionals are among the country's most experienced practitioners of hearing aid diagnostic services. We have been certified by Audigy Group, the largest member-owned organization in the hearing care industry. Audigy Group's purpose is to strategically select and certify the most elite practitioners in each market who exemplify the core values of Audigy's mission and vision in the delivery of hearing and diagnostic services.

Our shared mission is to deliver:

- Effective analysis and diagnosis of your hearing loss or balance condition
- Customized technology solutions that effectively integrate speech comprehension back into your life
- Unsurpassed patient satisfaction
- Excellence through continuing education
- Ongoing investment in the most advanced processes, procedures, and technology to ensure superior results for each patient.

Our practitioners understand "value" is not measured by price alone. Rather, value is in how well they utilize their knowledge and experience to create a customized solution to meet your hearing expectations and your lifestyle.