HEARING CARE OF SUMMERVILLE

PH (843) 871-9669 FAX (843) 871-8197

PATIENT'S NAME _____ AGE_____ DOB: _____ SEX_____

SS#_____ Marital Status: M S D W

HOME_____ WORK _____ CELL _____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

*Email:_____ HOW DID YOU HEAR ABOUT US? _____

REFERRING PHYSICIAN _____ PHONE_____

FAMILY PHYSICIAN _____ PHONE_____

EMPLOYER_____ OCCUPATION _____

SPOUSE/SIGNIFICANT OTHER_____ DOB_____

EMPLOYER_____ WORK PHONE_____

IF PATIENT IS A MINOR:

MOTHER'S NAME _____ **SS #** _____ **DOB**_____

EMPLOYER_____ **WORK #** _____

FATHER'S NAME _____ **SS#** _____ **DOB** _____

EMPLOYER _____ **WORK #**_____

INSURANCE COVERAGE

PRIMARY INSURANCE CARRIER _____ **POLICY #**_____
INSURED'S NAME _____ **INSURED'S DOB**_____ **EMPLOYER** _____

SECONDARY INSURANCE CARRIER _____ **POLICY #**_____
INSURED'S NAME _____ **INSURED'S DOB**_____ **EMPLOYER** _____

We accept Cash, Checks, Care Credit, and most major credit cards. A Fee of 30.00 is charged to you for all returned checks.

PHOTOCOPY OF YOUR INSURANCE CARD IS REQUIRED PRIOR TO TESTING.

Assignment of benefits/ financial agreement:

I hereby give lifetime authorization for payment of insurance benefits to be paid directly to Hearing Care of Summerville for services rendered. I understand I am financially responsible for all services.

I hereby authorize the healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

Signature: _____ **Date:** _____

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Patient name:_____ **Date:**_____

Referring Physician: _____ **Primary Physician:** _____

Would you like Hearing Care of Summerville to send a report to : (Check all that apply)

_____Referring Physician _____Primary Care Physician _____ Other: _____

Allergies (Food, medication, Other) _____

Do you have a hearing loss? _____ yes _____ no

If you answered yes, how long have you or your family and friends noticed your hearing loss? _____

Please check if you suffer from any of the following health conditions:

_____Diabetes
_____tonsillitis
_____high Cholesterol
_____chronic ear infections
_____asthma
_____ ever been administered chemotherapy
_____ ever been administered high levels of antibiotics
_____Memory problems / Dementia
_____HIV/AIDS
_____Hypertension
_____Sinusitis/ history of sinus surgeries
_____Parkinson's Disease
_____history of ear surgeries
_____ Renal/Kidney Disease
_____strokes
_____vision loss/glaucoma
_____Meniere's Disease
_____ Use of Viagra or Cialis

Please check if you have any of the following symptoms:

_____Dizziness/ off balance
_____Tinnitus / ringing in the ears
_____Family history of hearing loss
_____exposure to industrial or recreational noise
_____Ear fullness
_____Ear pain

Please check the following only *if* you have worn hearing aids in the past:

_____I like my hearing aids
_____I can hear in noise
_____my devices are a comfortable fit
_____My head is 'in a barrel'
_____I cannot use my current devices

What are your concerns you'd like to address during today's visit ? _____

_____

If you have noticed a hearing loss, please name three situations where you'd like to hear better:

1_____
2. _____
3. _____

Do you feel that you are a candidate for new hearing aids? _____ Yes _____ No

If you answered yes, please rank the following 5 items about hearing aids (1= most important, 5=least important)

_____ how the hearing aids look in my ears
_____ how much do the hearing aids cost / are they covered by my health insurance
_____ ease of use (how difficult is it to put them on and take them off)
_____ how long does a battery last
_____ a full service maintenance plan – free cleanings / supply of batteries / etc

Hearing Care of Summerville

Consent For Use and Disclosure of Health Information

Patient Giving Consent: _____ D.O.B: _____

Address: _____ City/State/Zip: _____

Phone#: _____ SS#: _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

By signing this form, you will give consent to our office, Hearing Care of Summerville, use and disclosure of your protected health information for treatment, payment and healthcare activities.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to sign the consent form. Our Notice provides detailed descriptions of our treatment, payment policies and procedures, healthcare operations and the uses and disclosure of your protected health information. A copy of the Notice is available and you are encouraged to read it carefully and completely prior to consent.

We reserve the right to change our privacy practices as described in the Notice of Privacy Practices. If we change the privacy practice, we will issue an amended or revised Notice which contains the changes. Those changes may apply to any of your protected health information we may have on file.

You have the right to request a copy of our Notice of Privacy Practices, including any revisions by contacting:

Contact: Hearing Care of Summerville, Anne Glynn, Office Manager

Address: 208 A East 2nd North St. Summerville, SC 29483 Phone: 843-871-9669 Fax: 843-871-8197

Right to Revoke: You have the right to revoke this Consent at any time by submitting a written notice of your revocation to the person and address listed above. Please understand that revocation of this authorization will not affect any action the above entity took in reliance on this consent before receiving your written revocation. However, we reserve the right to decline to continued treatment if you have revoked consent.

I, _____, have read and understand the contents of the Consent form and Notice of Privacy Practices. I understand that by signing this form, I give my consent for Hearing Care of Summerville to use and disclose my protected health information in order to carry out treatment, payment activities and health care.

Signature: _____ **Date:** _____

If the consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative: _____ Relationship to patient: _____

Protected health information may be used or disclosed to the following persons:

_____

_____

_____

Revocation of Consent: DO NOT SIGN THIS PORTION UNLESS YOU ARE REVOKING CONSENT

I revoke my consent for use and disclosure of my protected health information for treatment, payment and healthcare services. I understand revoking my consent will not affect any actions prior to this written Notice of Revocation.

I hereby revoke my consent for use and disclosure of health information.

Signature: _____ Date: _____

Hearing Care of Summerville

Medicare Requires " For Payment"

All Medicare Patients are to supply us a list of current medication and dosage of the medications.

If you have a list of your own, I will be more than happy to copy it for you.

Thank you.

Patient Name :_____

Date:_____

Please List Medications/Dosages.

1.

2.

3.

4.

5.