Welcome To Our Practice

We are happy to welcome you to our audiology and hearing aid office. We appreciate your trust in us to take care of you and your family. Our office is focused on providing you with the highest quality of care. Our friendly staff is here to assist you.

Please complete the enclosed forms and bring them with you on your first appointment:

- Patient Registration Form
- Health History Forms
- Financial and Payment Policy
- Privacy Notice
- Directions to Our Office are included

We accept Traditional Medicare Programs, and will bill the insurance for you, (We do not accept most HMO, Medicare HMO, Medi-Cal or Medicare Advantage Plans). Please inquire if we accept your insurance plan.

Please visit our websites for more information:

PacificHearingInc.com

Thank you for choosing our office, we look forward to meeting you.

Patient Registration Form

Email:____ Date:_____/______/______
PLEASE PRINT

To improve communication, I authorize the use of email: _________Initials Acct #__________________

Name:____
Last *First* *Middle Initial*

Birth Date:_______________Age:_________ Driver's License #:_____________________ State:_________

What is the reason for your visit today?____

Full name and address of referring physician:

____

____

Telephone number: _______________________Fax number: ______________________________________

Email Address of Physician:____

Full name and address of general physician/internist:

____

____

Telephone number: _______________________Fax number: ______________________________________

Email Address of Physician:____

Full names and addressed of other physicians you wish to receive reports:

____

____

____

Telephone number: _______________________Fax number: ______________________________________

Email Address of Physician:____

How did you hear about us? □ Newspaper □ Friend □ Relative □ Website □ Other________________

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim.

PATIENT SIGNATURE:____ DATE: __________________

Patient Information

Patient Name:			Soc Sec #:
Sex:	Birth Date:	Aliases:	
Street Address:		Home Phone:	
		Work Phone:	
City:		Mobile:	
State:	ZIP:	Comments:	
Email:			
Interpreter Needed: ☐ Yes ☐ No	Language:	Ethnicity: ☐ Hispanic ☐ Non-Hispanic	
Marital Status: ☐ Mar ☐ Sing ☐ Wid ☐ Div ☐ Sep		Race:	
☐ Deaf or Hard of Hearing	☐ Blind or Vision Impaired	Needs: ☐ Sign Interp ☐ Tactile Interp	Other:

Primary Care Provider Information

PCP:	Phone:	Group:

Emergency Contact

Contact Name:			
Street Address:		Home Phone:	
		Work Phone:	
City:		Mobile:	
State:	ZIP:	Comments:	
Email:			
Relationship to Patient:		Legal Guardian? ☐ Yes ☐ No	

Patient's Employer

Employer:		Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Disabled ☐ FT Student ☐ PT Student ☐ Not Employed ☐ Never Employed ☐ On Active Military Duty
Work Address:		
City:	Employment Date:	Employee ID:
ZIP:	Phone:	Occupation:

Guarantor Information	☐ Same as patient	
Guarantor Name:		Soc Sec #:
Sex:	Birth Date:	Aliases:
Street Address:	City:	Home Phone:
	ZIP:	Work Phone:
Relationship to Patient:		

Guarantor Employment		
Employer:		Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Disabled ☐ FT Student ☐ PT Student ☐ Not Employed ☐ Never Employed ☐ On Active Military Duty
Work Address:		
City:	Employment Date:	Employee ID:
ZIP:	Work Phone:	Occupation:

Primary Insurance Info	☐ Same as patient	☐ Same as guarantor	
Subscriber Name:			Soc Sec #:
Sex:	Birth Date	Aliases:	
Patient Relationship to Subscriber:		Subscriber ID:	Group #:
Home Address:			City:
			ZIP:
Primary Insurance Company & Plan			

Secondary Insurance Info	☐ Same as patient	☐ Same as guarantor	☐ Same as primary
Subscriber Name:			Soc Sec #:
Sex:	Birth Date:	Aliases:	
Patient Relationship to Subscriber:		Subscriber ID:	Group #:
Home Address:			City:
			ZIP:
Secondary Insurance Company & Plan:			

Thank you for helping us keep all your important information current!

HEALTH HISTORY FORM

Please write additional information on the back

PATIENT NAME________________________AGE__________DATE ______________

Height______'_______" Weight________lbs. Pain 0 1 2 3 4 5 6 7 8 9 10 Where? ______________

What is the reason for your visit today? ______________________________

Please List Your Pharmacy Name And Phone: ______________________________

LIST CURRENT MEDICATIONS,

Including Vitamins & Supplements (if you are taking aspirin/Advil or diet pills list the duration)

MEDICATION ALLERGIES			
OTHER ALLERGIES			

PAST MEDICAL HISTORY (type and date) :

Hospitalizations			
Operations			
Illnesses			
Injuries/Fractures			

REVIEW OF SYSTEMS (check any that apply):

EARS:	☐ Hearing Aids ☐ Exposure to Loud Noise	☐ Pain ☐ Tinnitus (noise in ears)	☐ Dizziness/Vertigo ☐ Discharge	☐ Surgery:__________ ☐ Other:__________
NOSE :	☐ Difficulty Breathing ☐ Snoring	☐ Stuffiness ☐ Nasal Sprays	☐ Bleeding ☐ Injuries	☐ Change in Smell ☐ Post Nasal Drip ☐ Surgery:__________
THROAT:	☐ Soreness Bad ☐ Taste Throat ☐ Clearing	☐ Pain or Difficulty Swallowing ☐ Recent Dental Work ☐ Voice Change/Hoarseness	☐ Tonsillitis ☐ Bad Breath ☐ Lump	☐ Cough ☐ Reflux ☐ Surgery:__________
NECK:	☐ Lumps ☐ Pain	☐ Thyroid Nodules ☐ Swollen Glands	☐ Injuries ☐ Surgery:__________	
EYES:	☐ Loss/Blurred Vision ☐ Crossed Eyes ☐ Lazy Eye ☐ Eye Disease	☐ Double Vision ☐ Itching, Burning, Irritation ☐ Floating Objects in Vision ☐ Cataracts	☐ Injuries ☐ Pain/Soreness ☐ Dryness of Eyes ☐ Light Sensitivity	☐ Excess Tearing ☐ Redness/Inflammation ☐ Glaucoma ☐ Surgery:__________

PERSONAL HISTORY:

☐ Anemia
☐ Angina/Chest Pain
☐ Anxiety
☐ Asthma
☐ Arrhythmia
☐ Bleeding Problems
☐ Chronic Lung Disease
☐ Constipation
☐ Colitis
☐ Diabetes
☐ Diarrhea
☐ Difficulty Urinating
☐ Eczema
☐ Emphysema
☐ Headaches
☐ Heart Failure/Attack
☐ Heartburn
☐ High Blood Pressure
☐ Autoimmune Disease
☐ Pain w/ Urination
☐ Cancer
☐ Hepatitis or Jaundice
☐ Kidney Disease
☐ Kidney Stones
☐ Liver Disease
☐ Lyme Disease
☐ Paralysis
☐ Prostate Problems
☐ Psoriasis
☐ Psychiatric
☐ Rashes
☐ Rheumatic Fever
☐ Sexual Dysfunction
☐ Shortness Of Breath
☐ Stroke
☐ Tuberculosis
☐ Ulcers
☐ Vaginitis
☐ Weight Loss or Gain

SOCIAL HISTORY :

- Smoke : ☐ YES ☐ NO_______packs per day • Drugs: ☐YES ☐NO__________type/amount • Caffeine: ☐ YES ☐ NO______cups per day
- Alcohol: ☐YES ☐NO_____________type/amount • Diet :__________________type
- Are you currently pregnant? ☐YES ☐NO Are you currently on a Contraceptive medication program? ☐YES ☐ NO

FAMILY HISTORY (check any that apply) :

☐ Asthma
☐ Allergies
☐ Headaches
☐ Diabetes
☐ Cancer
☐ Stroke
☐ High Blood Pressure
☐ Tuberculosis
☐ Autoimmune Disease
☐ Thyroid Disease
☐ Dizziness (vertigo)
☐ Eye Problems
☐ Hearing Loss
☐ Heart Disease
☐ Bleeding Problems

Has anyone in your family had an unfavorable reaction to anesthesia? ☐ YES ☐ NO Explain______________________

Is there anything else about your medical history that might be helpful for the doctor to know? ______________________

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim.

PATIENT SIGNATURE :______________________________DATE: ______________

06/04/19

PACIFIC HEARING & BALANCE

ADULT EVALUATION & MANAGEMENT RELEVANT HISTORY

PATIENT NAME (last)___________________________________ **(first)** ____

DATE OF BIRTH: __________________________________ **CHART #** _________________ **DATE:** _____________________

Audiologist: ___ Dr Frazer PhD, AuD ___ Dr Skille AuD ___ Kathy Harlan MA ___ Dr Krauss AuD ___ Dr Shalom AuD ___ Dr McManus AuD

NOTE: IF YOU ARE SCHEDULED FOR A HEARING TEST TODAY AND HAD A PREVIOUS HEARING TEST AT THIS OFFICE WITHIN THE LAST SIX MONTHS, YOU DO NOT NEED TO FILL OUT THIS FORM. THANK YOU!

HEARING CASE HISTORY	YES	NO	OFFICE USE ONLY: AUDIOLOGIST
Do you have difficulty hearing or known hearing loss?			
Do you have ringing or noises in your ear(s)?			
If yes, does it interfere with sleep or normal activities?			
Do you have exposure to loud noises (i.e. work or gun use?)			
Do you have past or recent head injury or ear surgery?			
Do you have ear pain or drainage?			
Do you feel pressure in ear(s) or feel plugged?			
Do you have dizziness, vertigo or balance problems?			
Do you have family members with hearing loss?			
Do you use tobacco or smoke?			
Do you turn the TV up louder than others prefer?			
Do you have difficulty understanding what is said on TV?			
Do you have difficulty hearing over the telephone?			
Do you miss some words and have to ask people to repeat?			
Do you have to strain to understand conversations in groups?			
Do you have trouble understanding in the presence of noise?			
Do you have trouble understanding in meetings or churches?			
Do you have trouble understanding females or children?			
Does it sound like people frequently mumble?			
Do people get annoyed because you don't understand?			
Do you avoid social activities due to your inability to hear?			
Have family members ask you to have your hearing checked?			
Do you have any vision or dexterity problems?			
For the past month, have you often felt depressed or hopeless?			
For the past month, have you often lacked interest or pleasure?			

For Office Use Only

Discussed test results & speech audiogram w/ patient?			

CONCLUSIONS/IMPRESSION: SNHL CHL MIXED HL AD AS AU SNHL CHL MIXED HL AD AS

RECOMMENDATIONS: ___ Medical &/or ENT follow up _____ Hearing Aid Evaluation _____ ABR _____VNG

OTHER RX:

PACIFIC HEARING & BALANCE

PEDIATRIC EVALUATION & MANAGEMENT RELEVANT HISTORY

PATIENT NAME (last)_________________________________ **(first)** ____

DATE OF BIRTH: ________________________________ **CHART #** ________________ **DATE:** ____________________

Audiologist: ___ Dr Frazer PhD, AuD ___ Dr Skille AuD ___ Kathy Harlan MA ___ Dr Krauss AuD ___ Dr Shalom AuD ___ Dr McManus AuD

HEARING CASE HISTORY	**YES**	**NO**	**OFFICE USE ONLY: AUDIOLOGIST**
Does the child have a known hearing loss?			
Does the child have suspected hearing loss?			
Is there family history of hearing loss?			
Is the child responsive to speech & environmental sounds?			
Does the child have any speech or language delays?			
Does the child have any developmental delays?			
Has the child had past or recent head injury or ear surgery?			
Has the child had ear infections? If so, how frequent?			
Did the mother have an abnormal pregnancy, birth and delivery?			
Did the child have abnormal status at birth?			
Was the child's birth weight less than 3 lbs and 5 oz?			
Has the child had any childhood illnesses or traumas?			
Did the child fail a hearing screening test?			

For Office Use Only

SUMMARY DETAILS:

Discussed test results & speech audiogram w/ parent?			

CONCLUSIONS/IMPRESSION: SNHL CHL MIXED HL AD AS AU Degree:

SNHL CHL MIXED HL AD AS Degree:

RECOMMENDATIONS: ___ Medical &/or ENT follow up ____ Hearing Aid Evaluation ____ ABR ____VNG

OTHER RX:

Financial and Payment Policy for Medical or Surgical Services

Insurance

If you have medical insurance, we are pleased to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. You will be asked to update your demographic and insurance information periodically, including providing our office with copies of your insurance card(s). We are required to obtain your signature for permission to release information to your insurance carrier annually.

_______initial

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. It is important to understand however, that **WE ARE IN NETWORK WITH MOST, BUT NOT ALL INSURANCE PLANS. PLEASE VERIFY WHAT YOUR INSURANCE COVERS. WE WILL BILL YOUR INSURANCE AND YOU ARE RESPONSIBLE FOR THE CO-INSURANCE, CO-PAYMENT OR DEDUCTIBLE IN ACCORDANCE WITH THE TERMS OF YOUR PLAN.** We are very sensitive to keeping health care costs affordable to our patients. As a result, we take great care to insure that our fees are consistent with the charges in the geographic region. Most reputable insurance companies consider our fees usual, customary, and reasonable. Not all services are a covered benefit in all contracts. It is the patient's responsibility and duty to have an understanding of the benefits and eligibility, stipulated under their individual insurance policy. **We may contact your insurance carrier to verify coverage information regarding audiology and hearing aids services.**

_______initial

Payment for Services

1. **Insurance Plans**: We accept most Non-HMO insurance plans. We will bill your insurance; you are responsible for Co-payments, Co-Insurance or Deductibles. If audiology hearing aid services are contracted, they will be billed under your In Network Benefits.
2. **Traditional Part B MEDICARE Patients**: We accept assignment and will bill Medicare, and most secondary Non-HMO insurances.
3. We do not accept most HMO, Medicare HMO, Medi-Cal or Medicare Advantage Plans. Please inquire if we accept your insurance plan.

It may become necessary for you to pay your account in full if your insurance company fails to pay for services. It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements**. We must emphasize that as hearing care providers, our relationship is with YOU, not your insurance company**. Your insurance is a contract between you, your employer and the insurance company.

_______initial

Assignment of Benefits

I request that payment of the authorized Medicare and/or other insurance benefits be paid on my behalf to my Provider. I hereby assign to my Provider all my rights, title, interest in and to any and all audiology and/or hearing aids benefits, otherwise payable to me. In absence of such payment, Provider is further assigned all necessary right to enforce collection of such payments or benefits, including the rights to file a lawsuit or demand arbitration directly against the insurer, plan or payer. I further agree that I am financially responsible for charges not collected by this Agreement. I authorize the provider to contact the employer and/or company responsible for the payment of any benefits for the purpose of determining the existence and extent of benefits, and I authorize the release of any and all information in possession of the employer and /or company necessary to determine the existence and/or extent of such benefits. For and in consideration of services rendered, I agree that this Provider shall have an irrevocable lien, equal to the charges for the services rendered on any recovery due the patient because of injury or illness which required this Providers' services, whether said recovery is by judgment, settlement, arbitration award, hearing award, compensation or insurance payment.

_______initial

Returned checks, balances older than 60 days, and failure to pay account balances as promised may be subject to external collection and additional collection fees, including attorney and other court fees. If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. Thank you.

My Signature below constitutes acknowledgement and acceptance of this policy.

______________________________	______________________________	________________	____________________
Patient or Guarantor Signature	Print	Date	Witness

NOTICE OF PRIVACY PRACTICES

Effective Date: September 2018

This Joint Notice of Privacy Practices (Notice) describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The Notice is being provided to you on behalf of **Pacific Hearing & Balance (PHB), and Pacific Hearing Inc (PHI**), its medical staff and other providers (collectively referred to herein as "we" or "our").

PHB and PHI are committed to protecting the confidentiality of your health information.
We are required by law to maintain the privacy of your Protected Health Information (commonly called health information), including health information in electronic format. We are also required to notify you of our legal duties and privacy practices regarding your health information and abide by the practices of this Notice, unless more stringent laws or regulations apply. This Notices applies to all PHI and PHB facilities, services and programs that provide healthcare to you.

Application of this Notice
The information privacy practices described in this Notice will be followed by:

- Any healthcare professional who treats you at any of our locations.
- All facilities, departments and units, including hospitals, surgical centers, home care, clinics and other affiliates.
- All workforce members such as employees, medical staff, trainees, students, volunteers and other persons under our direct control, whether or not they are paid by us.
- Other healthcare providers that have agreed to abide by this Notice of Privacy Practices.

This Notice provides detailed information about how we may use and disclose your health information with or without authorization, as well as more information about your specific rights with respect to your health information.

Uses and disclosures of your health information that we may make without your authorization
To Contact You: Your information may be used to contact you to remind you about appointments, provide test results, inform you about treatment options, or advise you about other health-related benefits and services.
Treatment: Your information may be shared with any healthcare provider who is providing you with healthcare services. This includes coordinating your care with other healthcare providers and providing referrals to other healthcare providers. Examples of healthcare providers who may need your information to treat you include, but are not limited to your doctor, audiologist, pharmacist, nurse, and other providers such as physical therapists, speech therapists, home health providers, and x-ray technicians. We may share your information electronically with your healthcare providers in order to make sure they have your information as quickly as possible to treat you.
We may share your health information with any family member or friend who is involved in assisting with your healthcare. We will only do this if you agree or do not object, and will only share with them the information they need in order to help you. If you are unable to either agree or object to such a disclosure, we may disclose your healthcare information as necessary if we determine that it is in your best interest based on our professional judgment. We may disclose health information to a family member, relative, or another person who was or is involved in your healthcare or payment for healthcare when you are deceased if not inconsistent with your prior expressed preferences.
Payment: In order to obtain payment for your healthcare services, we may have to provide your health information to the party responsible for paying. This may include Medicare, Medicaid (state health plan), or your insurance company. Your insurance company or health plan may need your information for activities such as determining your eligibility for coverage, reviewing the medical necessity of the healthcare services provided to you or providing approval for hospital services or stays.

Initial: ________

Healthcare Operations: Your health information may be used in order to support our business activities and to assure that quality healthcare services are being provided. Some of these activities include quality assessments, peer or

employee review, training of medical personnel, licensure and accreditation, data aggregation and audits by regulatory agencies.
We may share your health information with third parties who perform services such as transcription or billing. In those cases, we have written agreements with the third parties that they will not use or disclose your health information except if permitted by law.
This Notice also describes the privacy practices of an Organized Health Care Arrangement ("OHCA") between us and certain eligible healthcare providers and organizations. An OHCA allows legally separate covered entities to use and disclose health information for the joint operation of the arrangement. If we choose to participate in an OHCA arrangement, health care organizations will agree to work with each other in order to facilitate access to health information relevant to your care. For example, if you present to a hospital for emergency care and cannot provide important information about your health, the OHCA will allow us to use your health information from our OHCA participants to treat you. When it is needed, ready access to your health information means better care for you. We may store health information about our patients in a joint electronic health record with other health care providers who participate in this OHCA. PHI and PHB, and members of the OHCA must be able to share your health information freely for treatment, payment and healthcare operations purposes. For this reason, we have created this Joint Notice. OHCA members may choose to have their own Notice(s). For information about organizations participating in our OHCA, please contact the Privacy Office listed in this Notice.

Other uses and disclosures that we may make without your authorization
There are a number of ways that your health information may be used or disclosed without your authorization. Generally, these uses and disclosures are either required by law or for public health and safety purposes.
When Required by Law: We may use or disclose your health information when required by las. If this happens, we will comply with the law and will only disclose the information necessary.
Public Health: We may disclose your health information to a public health authority for public health activities. Public health activities include preventing or controlling disease, injury, disability, and responding to reports of abuse, neglect or domestic violence. We may disclose our health information to a person or agency required to report adverse events, products defects or problems, biologic product deviations, or for product recalls, repairs or replacements. As disclosures of this nature will be made consistent with state and federal law.

I, ____, have received or have been offered a copy of this 2 page Notice of Privacy Practices.
Signature: ____ Date: __________________

Initial: _______

Directions and Parking

For door to door directions visit us at: PacificHearingInc.com

Brentwood
11645 Wilshire Blvd. 6th Floor
Los Angeles, CA 90025

PARKING: The building has a subterranean garage for visitor parking. They charge $3 every 15 minutes, with a maximum of $24, Monday through Friday. After 6 pm and on weekends they charge a flat $2 fee. The automated system requires ticket payment in the parking foyer.

Limited metered street parking is available on Barry and the surrounding streets. Please be sure to read all posted signs and fill the meter

We are located on the 6th floor at
11645 Wilshire Blvd., Suite 601
between Federal and Barrington,
on the corner of Barry.

PLEASE CHECK-IN AT SUITE 600

Pacific Hearing, Inc.
11645 Wilshire Boulevard • Suite 601
Los Angeles, CA 90025
Tel (310) 909-0180 • Fax (310) 919-3181
PacificHearingInc.com