Patient Information

Please complete the following forms. 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).

Your Details:

Date: ______________________

First Name: ______________________

Last Name: ______________________

Middle Initial: ______________________

Email: ______________________

Acct #: ______________________

Birth Date: ______________________

Age: ______________________

Driver's License #: ______________________

State: ______________________

What is the reason for your visit today?

____

Referring physician:

First Name: ______________________

Last Name: ______________________

Address: ______________________

____

City: ______________________

State: ______________________

Zip Code: ______________________

Phone: ______________________

Fax: ______________________

Email: ______________________

General physician/internist:

First Name: ______________________

Last Name: ______________________

Address: ______________________

____

City: ______________________

State: ______________________

Zip Code: ______________________

Phone: ______________________

Fax: ______________________

Email: ______________________

Full names, addresses and phone numbers of any other physicians you wish to receive reports:

____

____

____

____

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.

Signature: ______________________

Date: ______________________

Patient Information

First Name: ______________________

Last Name: ______________________

Soc Sec #: ______________________

Sex: ☐ Male ☐ Female

Birth Date: ______________________

Aliases: ______________________

Address: ______________________

____

City: ______________________

State: ______________________

Zip Code: ______________________

Home Phone: ______________________

Work Phone: ______________________

Mobile: ______________________

Email: ______________________

Comments: ______________________

____

____

Interpreter needed? ☐ Yes ☐ No

Language: ______________________

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Race: ______________________

Marital Status:

☐ Married ☐ Single ☐ Widowed
☐ Divorced ☐ Seperated

Deaf or Hard of Hearing? ☐ Yes ☐ No

Blind or Vision Impaired? ☐ Yes ☐ No

Do you need any of the following:

☐ Sign Interpreter ☐ Tactile Interpreter ☐ Other

If "other" please specify:

____

Primary Care Provider Information

PCP: ______________________

Phone: ______________________

Group: ______________________

Emergency Contact

First Name: ______________________

Last Name: ______________________

Address: ______________________

____

City: ______________________

State: ______________________

Zip Code: ______________________

Home Phone: ______________________

Work Phone: ______________________

Mobile: ______________________

Email: ______________________

Comments: ______________________

____

Relationship to Patient:

____

Legal Guardian: ☐ Yes ☐ No

Patient's Employer

Employer: ______________________________

Work Address: ______________________________

____

City: ______________________________

State: ______________________________

Zip Code: ______________________________

Phone: ______________________________

Employment Date: ______________________________

Employee ID: ______________________________

Occupation: ______________________________

Status:

- ☐ Full Time
- ☐ Part Time
- ☐ Retired
- ☐ Disabled
- ☐ FT Student
- ☐ PT Student
- ☐ Not Employed
- ☐ Never Employed
- ☐ On Active Military Duty

Guarantor Information

☐ Same as patient

Guarantor Name: ______________________________

Soc Sec #: ______________________________

Sex: ☐ Male ☐ Female

Date of Birth: ______________________________

Aliases: ______________________________

Address: ______________________________

____

City: ______________________________

State: ______________________________

Zip Code: ______________________________

Home Phone: ______________________________

Work Phone: ______________________________

Relationship to Patient:

____

Guarantor Employment

Employer: ______________________

Work Address: ______________________

____

City: ______________________

State: ______________________

Zip Code: ______________________

Phone: ______________________

Employment Date: ______________________

Employee ID: ______________________

Occupation: ______________________

Status:

- [ ] Full Time
- [ ] Part Time
- [ ] Retired
- [ ] Disabled
- [ ] FT Student
- [ ] PT Student
- [ ] Not Employed
- [ ] Never Employed
- [ ] On Active Military Duty

Primary Insurance Information

- [ ] Same as patient Same as guarantor

Subscriber Name: ______________________

Soc Sec #: ______________________

Sex: [ ] Male [ ] Female

Date of Birth: ______________________

Aliases: ______________________

Patient Relationship to Subscriber:

____

Subscriber ID: ______________________

Group #: ______________________

Secondary Insurance Information

- [ ] Same as patient Same as guarantor Same as primary

Subscriber Name:

Subscriber Name: ______________________

Soc Sec #: ______________________

Sex: [ ] Male [ ] Female

Date of Birth: ______________________

Aliases: ______________________

Patient Relationship to Subscriber:

____

Subscriber ID: ______________________

Group #: ______________________

Home Address: ______________________

____

City: ______________________

State: ______________________

Zip Code: ______________________

Secondary Insurance Company & Plan:

____

Health History Form

Patient Name: ______

Age: ______

Date: ______

Height: ______

Weight: ______

Pain: ______

Pick a number between 1 and 10
based on level of pain ______

Where? ______

Pharmacy Name:

Pharmacy Phone: ______

Please list current medications
(including vitamins & supplements):

______

______

______

If you are taking aspirin/advil or diet pills please list the duration.

Medication allergies: ______

______

______

Other allergies: ______

______

______

Medical History

Hospitalizations: ______

Operations: ______

Illnesses: ______

Injuries/fractures: ______

Review of Systems

Please check any that apply

Ears:

- ☐ Hearing Aids
- ☐ Pain
- ☐ Dizziness/Vertigo
- ☐ Surgery
- ☐ Exposure to loud noise
- ☐ Tinnitus (noise in ears)
- ☐ Discharge
- ☐ Other

If you checked “surgery” or “other” please provide details:

______

______

Throat:

- ☐ Soreness
- ☐ Throat Clearing
- ☐ Recent Dental Work
- ☐ Tonsillitis
- ☐ Lump
- ☐ Reflux
- ☐ Bad Taste
- ☐ Pain or Difficulty Swallowing
- ☐ Voice Change/Hoarseness
- ☐ Bad Breath
- ☐ Cough
- ☐ Surgery

If you checked “surgery” please provide details:

______

______

Review of Systems (cont.)

Neck:

- [ ] Lumps
- [ ] Thyroid Nodules
- [ ] Injuries
- [ ] Pain
- [ ] Swollen Glands
- [ ] Surgery

If you checked “surgery” please provide details:

____

____

Eyes:

- [ ] Loss/Blurred Vision
- [ ] Lazy Eye
- [ ] Double Vision
- [ ] Floating Objects in Vision
- [ ] Injuries
- [ ] Dryness of Eyes
- [ ] Excess Tearing
- [ ] Glaucoma Surgery
- [ ] Crossed Eyes
- [ ] Eye Disease
- [ ] Itching/Burning/Irritation
- [ ] Cataracts
- [ ] Pain/Soreness
- [ ] Light Sensitivity
- [ ] Redness/Inflammation

If you checked “surgery” please provide details:

____

____

Personal History

Please check all that apply:

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

Social History

Please check all that apply

Smoke: ☐ Yes ☐ No

If yes, how many packs per day:

____

Alcohol: ☐ Yes ☐ No

If Yes, what type and how much:

____

Drugs: ☐ Yes ☐ No

If yes, what type and how often:

____

Caffeine: ☐ Yes ☐ No

If yes, how many cups per day:

____

Diet Type:

____

Are you currently pregnant? ☐ Yes ☐ No

Are you currently on a Contraceptive Medication Program?
☐ Yes ☐ No

Family History

Please check all that apply:

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

Has anyone in your family had an unfavourable reaction to anesthesia? ☐ Yes ☐ No

If yes, please provide details:

____

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 and insurance claim:*

Signature: ______________________________

Date:* ______________________________

Adult Evaluation & Management Relevant History

Note: if you are scheduled for a hearing test today and have had a previous hearing test at our office within the last six months, you do not need to fill out this form. Thank you!

Patient First Name: ______________________

Last Name: ______________________

Date of Birth: ______________________

Chart #: ______________________

Date: ______________________

Audiologist:

- ☐ Dr Frazer, PhD, AuD
- ☐ Kathy Harlan, MA
- ☐ Dr Shalom, AuD
- ☐ Dr Chwastyk, AuD
- ☐ Dr Skille, AuD
- ☐ Dr Krauss, AuD
- ☐ Dr McManus, AuD

Hearing Case History

Do you have difficulty hearing or known hearing loss?
☐ Yes ☐ No

Do you have ringing noises in your ear(s)?
☐ Yes ☐ No

If yes, does it interfere with sleep or normal activities?
☐ Yes ☐ No

Do you have exposure to loud noises (i.e. work or gun use?)
☐ Yes ☐ No

Do you have past or recent head injury or ear surgery?
☐ Yes ☐ No

Do you have ear pain or drainage?
☐ Yes ☐ No

Do you feel pressure in ear(s) or feel plugged?
☐ Yes ☐ No

Do you have dizziness, vertigo or balance problems?
☐ Yes ☐ No

Do you have family members with hearing loss?
☐ Yes ☐ No

Do you use tobacco or smoke?
☐ Yes ☐ No

Do you turn the TV up louder than others prefer?
☐ Yes ☐ No

Do you have difficulty understanding what is said on the TV?
☐ Yes ☐ No

Do you have difficulty hearing over the telephone?
☐ Yes ☐ No

Do you miss some words and have to ask people to repeat?
☐ Yes ☐ No

Do you have to strain to understand conversations in groups?
☐ Yes ☐ No

Do you have trouble understanding in the presence of noise?
☐ Yes ☐ No

Do you have trouble understanding in meetings or churches?
☐ Yes ☐ No

Do you have trouble understanding females or children?
☐ Yes ☐ No

Does it sound like people constantly mumble?
☐ Yes ☐ No

Do people get annoyed because you don’t understand?
☐ Yes ☐ No

Do you avoid social activities due to your inability to hear?
☐ Yes ☐ No

Have family members asked you to have your hearing checked?
☐ Yes ☐ No

Do you have any vision or dexterity problems?
☐ Yes ☐ No

For the past month, have you often felt depressed or hopeless?
☐ Yes ☐ No

For the past month, have you often lacked interest or pleasure?
☐ Yes ☐ No

Do you feel like you are currently a victim of physical, mental or financial abuse?
☐ Yes ☐ No

Pediatric Evaluation & Management Relevant History

Please skip this step if it is not relevant.

Patient First Name: ______________________

Last Name: ______________________

Date of Birth: ______________________

Chart #: ______________________

Date: ______________________

Audiologist:

- ☐ Dr Frazer, PhD, AuD
- ☐ Kathy Harlan, MA
- ☐ Dr Shalom, AuD
- ☐ Dr Chwastyk, AuD
- ☐ Dr Skille, AuD
- ☐ Dr Krauss, AuD
- ☐ Dr McManus, AuD

Hearing Case History

Does the child have a known hearing loss?

☐ Yes ☐ No

Does the child have suspected hearing loss?

☐ Yes ☐ No

Is there family history of hearing loss?

☐ Yes ☐ No

Is the child responsive to speech and environmental sounds?

☐ Yes ☐ No

Does the child have any speech or language delays?

☐ Yes ☐ No

Does the child have any developmental delays?

☐ Yes ☐ No

Has the child had past or recent head injury or ear sugery?

☐ Yes ☐ No

Has the child had ear infections?

☐ Yes ☐ No

If yes, how frequently?

____

Did the mother have an abnormal pregnancy,
birth or delivery?

☐ Yes ☐ No

Did the child have abnormal status at birth?

☐ Yes ☐ No

Was the child's birth weight less than 3lbs and 5oz?

☐ Yes ☐ No

Has the child had any childhood illnesses or traumas?

☐ Yes ☐ No

Did the child fail a hearing screening test?

☐ Yes ☐ No

PACIFIC HEARING INC.

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.

☐ I agree to the above terms*

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, COPAYMENT 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 ensure 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.**

☐ I agree to the above terms*

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.

☐ I agree to the above terms*

PACIFIC HEARING INC.

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, the Provider is further assigned all necessary rights 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 to 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.

☐ I agree to the above terms*

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 acknowledgment and acceptance of this policy.

Signature: ______________________________

Date: * ______________________________

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 Notice 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.

PACIFIC HEARING INC.

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.

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 read or have been offered a copy of the Noctice of Privacy

Signature: ______________________________

Date: * ______________________________