Corvallis
HEARING CENTER

PATIENT INFORMATION

Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Insurance (Provider & ID): _____

Circle all that apply: Female / Male | Employed / Retired / Other | Married / Single / Other

Emergency Contact: _____ **Phone:** _____

Referring Physician: _____ **Phone:** _____

VA Only - Full SSN : _____

HISTORY

Have you had trouble hearing? Y / N If yes, when did it start?: _____

Do you currently wear hearing aids? Y / N If yes, when were they purchased? _____

Have you seen a specialty doctor for ear problems? Y / N If yes, how long ago? _____

Do you have a history of working in noise or have noisy hobbies? Y / N

Have any relatives had hearing difficulty/loss? _____

Do you have any of the following? Circle all that apply:

Dizziness | Sudden Hearing Loss | Ear Drainage | Ear Pain | Ear Wax Blockage | Tinnitus | Ear Surgery | Outer Ear Abnormalities

_____ _____

Signature of Patient (or Personal Representative) Date

Release of Information and Assignment of Benefits

1. **Authorization Release of Information**
   I hereby authorize Corvallis Hearing Center to file insurance claim(s) on my behalf and release any information, including diagnosis and records of examination and treatment rendered to third party payers as required for claims to be processed.

2. **Authorization of Assignment of Benefits**
   I authorize Corvallis Hearing Center to file a claim on my behalf to my insurance provider and understand this does not mean a guarantee of payment. I understand that I may need to take an active part in the submission of any claims. I hereby authorize payment directly to Corvallis Hearing Center and will turn over any payment from my insurance provider that was paid to me on behalf of my hearing care provider.

3. **Disclaimer**
   The patient is ultimately responsible for full payment of all services rendered regardless of any insurance coverage or agreement he/she has made. Corvallis Hearing Center is not responsible if the patient's insurance provider has incorrectly informed Corvallis Hearing Center of their coverage and/or in the event the patient's policy changes without notification to Corvallis Hearing Center of these changes in coverage. If the patient fails to communicate with Corvallis Hearing Center and cooperate with payment as stated above, the patient's account will be turned over for collection and any charges assessed will be added to the patient's balance.

_____ _____

Signature of Patient (or Personal Representative) Date

_____

Printed Name of Patient (or Personal Representative)

Our Privacy Policy

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.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION:
Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment and personal demographics (i.e. address, date of birth, health insurance, etc.) This information serves as a basis for planning your care and treatment, and as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where and why others may access your health information and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS:
Your health record belongs to you, unless otherwise required by law that it is the physical property of the healthcare practitioner or facility that compiled it. You have the right to request a restriction on certain uses and disclosures of your information, and request amendments to your health record. This includes the right to obtain a paper copy of the notice of information practices upon request, inspect and obtain a copy of your health record.

OUR RESPONSIBILITIES:
This organization is required to maintain the privacy of your health information. This organization must abide by the terms of this notice; notify you if we are unable to agree to a requested restriction; accommodate reasonable requests you may have to communicate health information by alternative means or alternative locations. We reserve the right to change our practices and to make the provisions effective for all protected health information we maintain. We will not use or disclose your health information without your authorization, except as described in this notice.

YOUR HEALTH INFORMATION WILL BE USED IN THE FOLLOWING WAYS:

- We will use your health information for treatment. Information obtained by a healthcare practitioner will be recorded in your record and used to determine the course of treatment that should work best for you.
- We will use your health information for payment. A bill may be sent to you, or a third-party payer. The information on/or accompanying the bill may include information that identifies you, your diagnosis, procedures and supplies used.
- We will use your health information for regular health operations. Staff members may use information in your health record to assess your care and outcomes. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.
- We may disclose some of your health information to our Business Associates (i.e. hearing aid manufacturers or earmold labs) so that they can perform the work required. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.
- We may use or disclose information to notify or assist in notifying a family member, personal representative, or other person for your care, your location and/or general condition.
- We may disclose to a family member, other relatives, close personal friends or any other persons you identify, health information relevant to that person's involvement in your care or payment related to your care.

- As required by law, we may disclose to the FDA health information relative to adverse events with respect to product defects, or post marketing surveillance information to enable product recalls, repairs or replacements.
- We may disclose health information to comply with laws relating to workers' compensation or other similar programs.
- As required by law, we may disclose your health information to public health or legal authorities.
- We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

HIPAA BREACH NOTIFICATION RULE:
You have the right to be notified of any breach of unsecured Patient Health Information ("PHI") when there is reason to believe your PHI has been accessed, acquired, used or disclosed without authorization. The notification must explain how the breach happened, the nature of the PHI that was breached and what steps you should take to protect yourself from harm as a result of the breach.

IDENTITY THEFT PREVENTION AND DETECTION:
It is the policy of this practice to follow all federal and state laws in protecting your private information and reporting requirements regarding identity theft as per the Red Flag Rules compliance program. To protect your identity we may ask for the following in order to protect you:

- Driver's license or other type of photo ID
- Current health insurance card
- Utility bill or other correspondence showing current residence if your photo ID does not show a current address

Should we suspect fraudulent activity (a red flag), we reserves the right to:

- Cancel the transaction
- Contact the appropriate enforcement
- Notify the affected person
- Notify the affected Physician(s), Audiologist(s), and Hearing Specialist(s)

FOR MORE INFORMATION, OR TO REPORT A PROBLEM:
If you have questions and would like additional information, you may contact Corvallis Hearing Center. If you believe your privacy rights have been violated, you can file a complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I hereby acknowledge that I have read the Notice of Privacy Practices of Corvallis Hearing Center. I have read and understand and I have had an opportunity to ask questions about the use and disclosure of my protected health information, and other concerns regarding my protected health information.

_____ _____

Signature of Patient (or Personal Representative) Date

PATIENT CONSENT TO RECORDING

Please be advised that for quality improvement, training, accuracy of medical records, and enhanced patient safety and experience, the undersigned hereby gives consent to Corvallis Hearing Center to audio record patient interactions with clinicians, employees and agents including, without limitation, interactions occurring during examinations, fittings, consultations and phone calls. In the event the recordings (all or any part of any recording) are considered Protected Health Information (PHI), such recordings shall be subject to the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules. We are committed to safeguarding your privacy and confidentiality, and any recordings containing PHI will be stored securely using encryption and access controls, ensuring only authorized personnel have access and only disclosed, shared or used in accordance with any/all applicable laws/regulations, including without limitation, HIPAA and will not otherwise be shared without your express written consent unless required by law. These recordings may also be integrated into your medical records. Please understand that your care will not be conditioned on providing consent, declining or revoking consent shall not affect the quality of care or treatment, and you have the right to revoke your consent at any time. You at any time may request in writing access to your recordings or obtain a written copy of your records. If you have any concerns or questions regarding this policy, please do not hesitate to speak with a member of our staff.

By verbally acknowledging and/or signing below, you confirm that you have read and understand this consent form, agree to the terms herein, and voluntarily consent to the audio recording of your visit, treatment, consultation, or any other related interaction with our staff and any other authorized personnel or related third parties. This consent may be revoked by you at any time by notice to us.

_____ _____

Signature of Patient (or Personal Representative) Date

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Printed Name of Patient (or Personal Representative)