Professional Hearing Associates
Serving San Diego Since 1984
www.hearinginfo.net

1045 East Valley Parkway
Escondido, CA 92025
760-489-6901

PATIENT INFORMATION

First Name:_____ Middle Initial:_____ Last Name:_____
Age:_____ Date of Birth:_____ Gender:_____
Pediatrician:_____Pediatrician Phone:_____
ENT (if applicable):_____ENT Phone:_____
School (if applicable):_____School Phone:_____
I consent to release/exchange information to my child's:
Pediatrician_____ ENT_____ School_____ Other_____ _____
Initial initial initial name/phone initial

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name(s):_____
Relationship to Patient:_____
Street Address:_____ City:_____ State:____ Zip_____
Home Phone:_____ Cell:_____ Email:_____

How did you hear about Professional Hearing Associates, Inc.? (Please check one):
_____ Physician _____ Friend _____ Newspaper Ad _____ Online _____ Other
Referred by: _____

INSURANCE INFORMATION: PLEASE BRING IN ALL YOUR INSURANCE CARDS

For accurate claim submission we will need to make a copy. Please verify that all cards are legible, current and that all information (ID number, group, claim address) is correct.
Primary Insurance: _____
Secondary Insurance: _____
If primary on insurance is not patient: Primary Name: _____ Primary DOB: _____

SIGNATURE AUTHORIZATION

Professional Hearing Associates, Inc. is a privately owned company and all scheduling and billing will be conducted through the corporation. I authorize direct payment of any medical benefits for services performed at Professional Hearing Associates, Inc., be sent directly to the Escondido office. I understand that I am ultimately responsible for the balance on my account for any professional services rendered. Professional Hearing will be happy to assist me with filing insurance, but I understand it is my responsibility to know the rules and regulations of my specific plan, as well as what coverage is included on my plan. It is also my responsibility to contact my insurance carrier to determine if Professional Hearing Associates, Inc is in my specific network.

I authorize Professional Hearing Associates, Inc. to release any information relating to the service obtained here and those services related to my treatment to other professionals and insurers as may become necessary.

I understand that it is my responsibility to notify Professional Hearing Associates, Inc. if I am unable to keep my scheduled appointment. Failure to give appropriate notice of cancellation may result in a "no show" $35 fee for which I will assume responsibility. I also permit a copy of this authorization to be used in place of the original. I have read and agree to the above Signature Authorization section and comprehend that it will remain in effect until revoked by me in writing.

Signature:_____Date: _____

Our Financial Policy

ASSIGNMENT OF INSURANCE BENEFITS

Patients with insurance please read and sign below:

Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims or accept responsibility for negotiating claims with your insurance company. As a courtesy we will be happy to help you determine the coverage you have available.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans to Professional Hearing Associates, Inc. A photocopy of my insurance card (assignment) and a copy of my driver's license are to be considered as valid as an original.

I am financially responsible for all charges whether or not paid by the above insurance. I hereby authorize Professional Hearing Associates, Inc. to release all information necessary to secure payment. If insurance pays only a portion of the bill or fails to make payment to Professional Hearing Associates, Inc. within 90 days, I will be responsible for payment of balance in full at that time.

Patient Name:_____ Parent Name:_____

Parent Signature:_____ Date:_____

MEDI-CAL/MEDICAID PATIENTS:

Patients with Medi-cal/Medicaid please read and sign below

Professional Hearing Associates, Inc., is not a provider for Medi-cal/Medicaid insurance. I understand that I am responsible for all coinsurance and/or deductibles due by Medicare and/or other insurances, and will be billed for these amounts due.

Patient Name:_____ Parent Name:_____

Parent Signature:_____ Date:_____

AUDIOLOGIC CASE HISTORY: (PLEASE CIRCLE ANSWER)

Name:_____ Date of Birth:___/____/_____

Family Physician:

I consent for the provider/Audiologist to share the findings of today's appointment with my primary care physician: ____initial

Main Concern:

Secondary Concern:

PLEASE CIRCLE ANSWER:

(YES) (NO) History of Smoking?

(YES) (NO) History of Diabetes?

(YES) (NO) Family History of Hearing Loss?

(YES) (NO) Have you ever had your hearing tested?

By Whom/Date? _____

(YES) (NO) Pain in ears?

(YES) (NO) Chronic ear infections as a child or adult?

(YES) (NO) Drainage from ears?

(YES) (NO) Dizziness or Vertigo?

(YES) (NO) Ringing in ears/Tinnitus? If yes, please fill out the enclosed THI form.

(YES) (NO) Sudden or rapid hearing loss in the last 90 days?

(YES) (NO) Broken Eardrum?

(YES) (NO) Head, Neck, or Ear Surgery?

(YES) (NO) History of Exposure to Loud Noise?

(YES) (NO) Concerns about Hearing Loss?

If yes, in which ear (s) (RIGHT) (LEFT)

(YES) (NO) Is hearing the same in both ears?

If no, which ear has better hearing? (RIGHT) (LEFT)

(YES) (NO) Do you have a pacemaker or other implantable device?

(YES) (NO) Experience wearing a hearing device?

In what year was the device purchased?

Please describe any problems you encountered with your current device(s):

Do you have difficulty using the home telephone? (Yes) (No) If yes, would you like us to register you to receive an amplified caption telephone at no charge? (Yes) (No).

NOTICE OF HEALTH INFORMATION PRACTICES

Professional Hearing Associates.

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

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 of hearing health care. For example, we may use and disclose your information to consult with a third party or to refer you to other health care 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 health care. For example, we may need to give your health plan information about treatment you received 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.

• Health care 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.

This Notice of Privacy Practices requires us to:

1. Keep your medical records private and to 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.
3. 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 is a description of the different circumstances that may require our practice to use or disclose your medical information:

1. Share medical data with another provider who is responsible for your care (physicians, audiologists, nurses, any other healthcare professionals, technicians, students in healthcare, or any other people who take care of you), make referrals and/or placing lab/prescription orders.
2. Share your health insurance plan information about a treatment you received at our practice when filing a claim for reimbursement or determination of benefits.
3. Provide treatment communications concerning treatment alternatives or other heath 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.
4. Disclose medical information to a medical examiner to identify a deceased person or to determine the cause of death, or for tissue donations.
5. Medical information may be disclosed if you are military personnel, either active or a veteran, and if required by the appropriate authorities.
6. Share medical data to the public health and or law enforcement official whose job is to prevent or control disease, injury, or disability.
7. Share medical data with a representative from the Food and Drug Administration for the purpose of reporting adverse effects stemming from defective products, etc.
8. Medical information may be disclosed when necessary to comply with Workers' Compensation.
9. Medical information may be disclosed in response to a court and or administrative order in a lawsuit or similar proceeding.
10. In order to contact you for fundraising activities supported by our practice. You have the option to opt out of receiving these communications by sending a written request to the privacy officer.
11. 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.

12. 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 the more stringent requirements.

13. 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.

14. Share information about your condition(s), location and/or death to family member(s), or your personal representative(s). Prior permission by you will be obtained unless in case of emergency. If we are unable to obtain permission, we will share only the heath information directly necessary for your healthcare.

You have individual rights as part of the notice of Privacy Practices. As our patient you have the right to:

1. Request our practice to 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 pertain to a healthcare term or service which you paid for in full and 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, and (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 to different locations. This request must be made in writing to our practice.

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 health are professional or office personnel believe the patient's health information is complete and accurate, her she can refuse to make the requested changes. This request must be made in writing to our 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.

7. Request a paper copy if you have received this Notice of Privacy Practices electronically. This request must be made in writing to our practice.

If you have any questions regarding our privacy practices or think we may have violated your privacy rights, please contact us at: 760-489-6901 - Cole Stasek Au.D., Owner - 1045 East Valley Parkway, Escondido, CA 92025,

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

Office for Civil Rights
US. Department of Health and Human Services
200 Independence Avenue, S. W.
Room 509F, HHH Building
Washington, D.C. 20201

This practice is determined to protect the privacy of your medic al 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, obtain payment, and to conduct health care are operations in.

Acknowledgment Form.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

PATIENT PRINTED NAME:_____ PARENT PRINTED NAME:_____DATE:_____

PARENT SIGNATATURE:_____

This Notice shall be effective as of September 5, 2013