PROFESSIONAL HEARING ASSOCIATES, INC.

(760) 489-6901
Fax: (760) 489-1694

PATIENT INFORMATION

First Name _____ Middle Initial _____ **Last Name** _____
Address (Street) _____
City _____ **ST:** _____ **Zip:** _____
Home Phone: _____ Work Phone: : _____ Cell: : _____
Birth Date _____ Male _____ Female _____
Primary Physician: _____
E-mail _____

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

Patient's Occupation: _____ Employer _____
Full-time student? Yes ____ No _____ Parent's Name(s) (if pt. is under 18) : _____
Marital Status: Married ____ Divorced ___ Single ____ Separated ____ Widowed ____
Spouse Name or Emergency Contact _____ Phone #_____

INSURANCE INFORMATION

If you have any insurance and would like us to verify if there are any benefits, please bring all insurance cards to our office. Please make sure all the information is correct, current and legible.

Primary Insurance: _____
Secondary Insurance: _____

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: _____

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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?

(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).**

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Lifestyle Hearing Analysis

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

Please answer the following questions as honestly and precisely as possible. Thank you.

Listening Environments	How well do you currently hear in this environment?			How frequently are you in this listening environment?		
	Well	Fair	Poor	Several times per week	Several times per month	Less than once a month
One-on-One Conversations	☐	☐	☐	☐	☐	☐
Quiet Room (2-3 people)	☐	☐	☐	☐	☐	☐
Small Groups (4-6 people)	☐	☐	☐	☐	☐	☐
Large Social Gatherings	☐	☐	☐	☐	☐	☐
In the Work Place	☐	☐	☐	☐	☐	☐
Watching Television	☐	☐	☐	☐	☐	☐
During Religious Services	☐	☐	☐	☐	☐	☐
Meetings/Lectures	☐	☐	☐	☐	☐	☐
In the Car	☐	☐	☐	☐	☐	☐
Outdoors	☐	☐	☐	☐	☐	☐
On the Telephone	☐	☐	☐	☐	☐	☐

	Very Little	Somewhat	Very Much
How important is it for you to hear better?	☐	☐	☐
If hearing aids are recommended, how motivated are you to wear them consistently?	☐	☐	☐
How much do you think that hearing aids could improve your hearing?	☐	☐	☐

Please rate how much importance you place on the following:

	Not important	Somewhat Important	Very Important
Hearing aid size and visibility	☐	☐	☐
Improved ability to hear and understand speech	☐	☐	☐
Improved ability to understand speech in noisy situations	☐	☐	☐
Cost of hearing aids	☐	☐	☐

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NOTICE OF HEALTH INFORMATION PRACTICES

Professional Hearing Associates, Inc.

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 health 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.

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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 health 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 pertains to a healthcare item 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 healthcare professional or office personnel believe the patient's health information is complete and accurate, he/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 exception.
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: David Michael Illich, Au.D., Owner - 1045 East Valley Parkway, Escondido, CA 92025, 760-489-6901

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
U.S. 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 medical 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 healthcare operations in our office.

Acknowledgment Form

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

_____
Name (Printed)

_____ _____
Signature Date

This Notice shall be effective as of September 5, 2013.