PROFESSIONAL HEARING ASSOCIATES, INC.
(760) 489-6901
Fax: (760) 489-1694

PATIENT INFORMATION

First Name:_____ Middle Initial:_____ Last Name:_____
Age:_____ Date of Birth:_____ Gender:_____ Social Security:_____
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_____ Google_____ Facebook_____ Other_____
Referred by: _____

INSURANCE INFORMATION

PLEASE BRING IN ALL OF YOUR INSURANCE CARDS

For accurate claim submissions 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:_____

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/Guardian 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/Guardian Signature Date

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Pediatric Case History Form (Ages 5-18)

Auditory and Hearing Information

1. Do you feel your child has a hearing problem? If so, why?_____

_____

2. When was the hearing problem first noticed?_____
3. Does your child have a history of ear infections? Yes☐ No☐ When was the last one?_____
4. Describe any previous treatment or testing your child has received regarding his/her ears or hearing:

_____

_____

5. Has your child ever been exposed to a loud noise or explosion? Yes☐ No☐
6. Does your child ever complain about fullness or noise in the ears? Yes☐ No☐
7. Does your child become confused with the direction from which sound is coming? Yes☐ No☐
8. Does your child seem to watch a speaker's face closely for cues as to what is being said? Yes☐ No ☐
9. Does your child respond to the following?
   His/her name ____ Loud Noises____ Soft Noises ____ Verbal Commands___ Vibrations____
10. Check any of the following additional services which your child has received:
    ☐ Speech/language evaluation or therapy ☐ Academic tutoring ☐ Occupational therapy
    ☐Psychological testing ☐ Special Education ☐Genetic evaluation ☐Neurological evaluation
    ☐Physical therapy ☐ Auditory processing evaluation
11. Does any member of your family have a hearing problem and/or wear a hearing aid? Yes ☐ No☐
    If so, please describe: _____

Pregnancy and Birth Information

1. Any unusual illness during pregnancy? Yes☐ No☐ (Measles, Rh factor, diabetes, toxemia, high blood pressure)
2. Length of pregnancy: _____ months/weeks
3. Length of labor: _____ hours
4. Child's birth weight: _____ lbs. _____ oz.
5. Check any of the following which apply:
   ☐Breech ☐Planned C-section ☐Trouble breathing/Required oxygen
   ☐Incubator used ☐Emergency C-section ☐Jaundice
   ☐Instruments used ☐Discoloratio ☐Other_____
6. Was your child in Neonatal Intensive Care Unit? Yes☐ No☐ If yes, for what reason?
_____ For how long? _____

Developmental information

1. List the age at which your child achieved the following skills:

a. Sat alone _____ b. Crawled _____ c. Walked alone _____ d. Fed self _____
e. Toilet trained _____ f. Dressed self _____
2. Child's physical development has been _____ (fast, slow, normal)
3. Which hand does your child prefer to use? Left / Right

Medical Information

1. Check the illnesses or conditions that your child has or has had in the past:

☐ Coordination problems ☐Recurrent headaches ☐High fevers ☐Attention deficit disorder
☐Swallowing difficulties ☐Chicken pox ☐Tonsillitis ☐Cerebral Palsy ☐
Allergies
☐Serious accident(s) ☐ Meningitis ☐Eye problems ☐Down Syndrome ☐Flu
☐Mumps ☐Feeding difficulties ☐ Dizziness ☐Cognitive delays ☐Measles
☐Surgery ☐Convulsions/seizures ☐ Other:_____

2. List any current medications the child is taking and the reason:

_____

_____

Speech and Language Information

1. Have you had any concern regarding your child's speech and language development? Yes ☐ No☐
2. Did your child smile and cry appropriately as an infant? Yes ☐ No☐
3. At what age did your child do the following:
   Babble _____ Use words _____ Use phrases_____
4. Do any family members have speech difficulties? Yes☐ No☐ If yes, please describe. _____

_____

5. Is your child aware of their communication problem? Yes☐ No☐
6. How do you communicate with your child? _____
7. Can your child follow simple verbal instructions? Yes☐ No☐
8. How does your child make his/her needs known to you? _____
9. Check any of the following that apply to your child:

☐ Poor listening comprehension ☐Pronounces sounds incorrectly ☐Talks very little
☐ Leaves out words ☐ Repeats or hesitates when talking ☐ Difficulty maintaining eye contact
☐ Reverses word order ☐ Uses incorrect or immature grammar ☐Uses gestures rather than speech
☐ Talks too rapidly or too slowly

Behavioral Information

Check any of the following that relate to your child's behavior:

☐Demands attention ☐ Under unusual stress at home ☐Impulsive
☐Lacks confidence ☐Withdrawn ☐Short attention span
☐Nervous or sensitive ☐Easily distracted ☐Makes inappropriate comments
☐Tires easily ☐Hyperactive ☐Overly sensitive to loud noises
☐Lacks motivation ☐Cries easily ☐Confused in noisy places
☐Underachiever ☐Slow learner ☐Prefers to play alone
☐Daydreams ☐Easily frustrated ☐Talks excessively

Educational Information

1. Has your child ever repeated a grade? Yes☐ No☐ If so, which grade and why: _____

_____

2. Has your child ever received any special help at school? Yes☐ No☐ If so, describe:_____

_____

3. Does your child like school? Yes☐ No☐
4. What are his/her best subjects?_____
5. Please indicate the subjects that are difficult for your child: _____
6. Has your child had a behavioral problem at school? Yes☐ No☐ If so, describe:

_____

_____

7. Have any of your child's teachers ever requested that his/her hearing or vision be tested? Yes☐ No☐
8. Does your child have problems paying attention or following directions in the classroom? Yes☐ No☐
9. Is there any history of learning problems in your family? Yes☐ No☐
10. Please describe any additional information about your child's behavior, schooling, health, etc., which you feel is important:

_____

_____

Signature of person completing the form_____

Relationship to client:_____Date:_____

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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.

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.