Dr. Jamie Lantz - Professional Hearing Center

Adult History – Audiology

4257 Route 9 North, Bldg 6, Suite B
Freehold, NJ 07728

Patient Information **Date:**_____

Patient Name _____ _____ **DOB** ___/___/____
First Name Last Name M D Y

Sex: _____ M _____F _____Other _____ Married _____ Single

Mailing Address_____

City _____ **State** _____ **Zip Code** _____

Adult Community_____

Home Phone # _____ **Cell Phone #** _____

Work Phone # _____ **Occupation**_____

E-mail Address _____

Spouse Name _____

Emergency Contact _____**Phone #** _____
Relation to Patient _____

Primary Care Physician _____ **Phone #** _____
Physician Address_____

How did you hear about us?

_____Website _____Newspaper Ad _____ Facebook
_____Insurance _____Mail

_____Referred by Physician_____
_____Friend _____
_____Other _____

Primary Concern:

_____

_____

_____

If you suspect a hearing loss, how long have you noticed this problem?_____

What do you feel is the cause of your hearing loss?_____

_____

Was the onset gradual or sudden?_____

Do you feel that your hearing is better in one ear versus the other? ____ Yes ____ No
If yes, which ear is better? _____ Right _____ Left

Have you previously had a diagnostic hearing test? _____ Yes _____ No
If yes, how long ago?_____ Results?_____

Do you have a history of ear infections? _____ Yes _____ No
If yes, when was the last infection?_____

Have you ever had ear surgery? _____ Yes _____ No
If yes, when and what type of surgery?_____

_____

Is there any family history of hearing loss? ____ Yes _____No
If yes, who?_____
If known why?_____

Tinnitus:

Do you have problems with tinnitus (ringing/noise in the ears)? ____Yes _____ No _____ Not Sure
If yes, please describe the type of noise: _____
Which ear? ____ Left _____ Right _____ Both
How often? _____

Dizziness:

Do you have or have experienced problems with dizziness? ____ Yes _____No
Describe:_____
How often?_____

Noise Exposure:

Have you ever been exposed to loud noise, recently or in the past? _____Yes _____ No

_____ Firearms _____ Factory Work _____ Military equipment _____Power Tools
_____ Explosions _____ Heavy Equipment _____ Motorcycles/recreational vehicle
_____Other_____

Please check if you have experienced any of the following:

_____ Excessive ear wax
_____ Ear drainage/bleeding
_____ Swimmer's Ear
_____ Ear pressure/fullness
_____ Popping sensation in the ear
_____ Ear Pain
_____ Fluctuating hearing loss
_____ Fluid behind the eardrum
_____ Sensitivity to loud noises

Please check if you have been diagnosed with any of the following:

_____ Otosclerosis
_____ Cholesteatoma
_____ Sudden hearing loss
_____ Labyrinthitis
_____ Meinere's disease
_____ Barotrauma
_____ Bell's palsy
_____ Ossicular Dislocation/fixation
_____ Acoustic neuroma

Medical History:

Do you smoke? _____Yes _____ No _____
How many alcoholic drinks do you consume in a week? _____

Cognitive Impairment:
Have you been evaluated or diagnosed for Dementia/Alzheimer's? _____ Yes _____ No

_____

_____

Dental History:

Have you had any dental procedures with the last six months? _____ Yes _____ No

Have you ever been diagnosed with Temporomandibular joint dysfunction (TMJ)? _____Yes ____No

Please check if you have experienced any of the following:

_____ Heart Disease
_____ Kidney or renal problems
_____ High blood pressure
_____ Meningitis
_____ Chronic sinus infections
_____ Pacemaker
_____ Diabetes
_____ Measles
_____ Environmental allergies
_____ Cancer
_____ Multiple Sclerosis
_____ Liver Problems
_____ Hypothyroidism
_____ HIV/AIDS
_____ Radiation/chemotherapy
_____ Asthma
_____ Tuberculosis
_____ Long term IV antibiotics
_____ Mental illness
_____ Visual Problems
_____ Head trauma
_____ Depression
_____ Anxiety
_____ Hepatitis A,B or C
_____ Migraines
_____ Loss of Consciousness

Recent Hospitalizations:_____

_____

Medication Record

Patient Name:_____

Date of Birth:_____

Medication	Dosage	Frequency (i.e. 2 x per day)	Route (pill, Injection)	Reason

Additional Comments/Concerns

Audiologist Signature:_____ Date:_____

List the top three listening situations where you would like to hear better.

1. _____
2. _____
3. _____

Hearing Aids:

Have you ever, or do you currently wear hearing aids? _____Yes _____No

If yes, when did you start wearing hearing aids? _____

Do you wear hearing aids now? _____Yes _____No

Which ear? ____Right ___Left ___Both

Insurance Information

Patient Name _____ _____
First Name Last Name

*Primary Insurance*_____

Name of Policy Holder _____ _____
First Name Last Name

Relationship of Patient to Policy Holder _____

Policy Number _____ **Group Number**_____

Insured Party's Date of Birth ____/____/_____
M D Y

*Secondary Insurance*_____

Name of Policy Holder _____ _____
First Name Last Name

Relationship of Patient to Policy Holder _____

Policy Number _____ **Group Number**_____

Insured Party's Date of Birth ____/____/____
M D Y

Notice of Privacy Practices

I give permission to Professional Hearing Center to release information, verbal and written, contained in my medical records and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons.

I authorize Professional Hearing Center to use and release my protected health information, i.e., my contact information, for marketing/email/newsletters related to hearing care products or services.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.

I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge, and hereby give my Professional Hearing Center permission to treat my concerns.

Name:_____ Date:_____

I authorize Professional Hearing Center to release information to the following:

Physician Name_____
Address_____
Phone number _____

Other:_____
Address_____
Phone number _____

Other persons authorized to discuss and or receive my health information:

I authorize the staff or audiologist at Professional Hearing Center to discuss my healthcare, diagnosis, test results, procedures, prognosis, insurance and billing information with the following person(s) for the purpose of my treatment or payment of services rendered.

Name:_____ Relationship_____ Phone _____

Name:_____ Relationship_____ Phone _____

Name:_____ Relationship_____ Phone _____

Patient Signature _____ Date: _____

HEALTH INSURANCE PORTABILITY & FINANCIAL ACCOUNTABILITY ACKNOWLEDGMENT: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

I. Professional Hearing Center is required by law to protect the privacy of my health information, often referred to as protected health information or PHI, which may include individually identifiable information that relates to my past/present/future physical or mental health condition and provision of health care and/or past/present/future payment for health care.
Upon request, Professional Hearing Center will provide me with a copy of this notice describing the privacy practices and legal duties and to explain how, when, and why Professional Hearing Center may use or disclose my protected health information.

II. HOW PROFESSIONAL HEARING CENTER MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION

The following categories describe different ways that Professional Hearing Center may use or disclose medical information about you. For each category, we have provided useful examples:

- **Treatment** means the provision, coordination, or management of your health care, including consultations between doctors, nurses, and other providers, regarding your care and referrals for care from one provider to another. For example, your ENT doctor may disclose your protected health information to the audiologist if he/she is concerned that you have an auditory problem.
- **Payment** means the activities Professional Hearing Center carries out to bill and collect for the treatment and services provided to you. For example, Professional Hearing Center may provide information to your insurance company about your medical condition to determine your current eligibility and benefits. We may also provide PHI to outside billing companies and others that process health care claims.
- **Health Care Operations** means the support functions that help operate Professional Hearing Center such as quality improvement studies, case management, responding to patient concerns, and other important activities. For example, Professional Hearing Center may use your PHI to evaluate the performance of the staff that cared for you or to determine if additional services are needed.

III. OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

In addition to using and disclosing your protected health information for treatment, payment, and health care operations, Professional Hearing Center may also use your information in the following ways:

- **Appointment Reminders and Health-Related Benefits or Services.** Professional Hearing Center may use PHI to contact you for a medical appointment or to provide information about treatment alternatives or other health care services that may benefit you. This may include receiving emails, text messages, and phone calls regarding services from Professional Hearing Center and affiliates.
- **Disclosures to Family, Friends, and Others.** Professional Hearing Center may disclose your PHI to family, friends, and others permitted and identified by you as involved in your care or the payment of your care. Professional Hearing Center may use or disclose PHI about you to notify others of your general condition. We may also allow friends and family to pick up goods related to your hearing health when determined that it is in your best interest to do so. If you are available, we will give you the opportunity to object to these disclosures.
- **To Avoid Harm.** As permitted by law and ethical conduct, we may use or disclose protected health information if we, in good faith, believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public, or is necessary for law enforcement to identify or apprehend an individual.
- **Fundraising & Marketing Activities.** Professional Hearing Center may contact you as part of any fundraising or marketing activities as permitted by law.
- **Research Purposes.** In certain circumstances, we may use and disclose PHI to conduct medical research. Certain research projects require an authorization which will be made available to you prior to using your PHI.
- **Lawsuits & Disputes.** If you are involved in a lawsuit or dispute, Professional Hearing Center may disclose health information about you in response to a court or administrative order. We may also disclose health information in response to a subpoena, discovery request, or other process by others involved in the dispute. Professional Hearing Center will only disclose information with assurance that efforts were made to inform you about the request or to obtain an order protecting the information requested.
- **Required by Law Enforcement.** Professional Hearing Center may release health information about you if asked to do so by law enforcement in response to a court order, subpoena, warrant, summons, or similar process. We also may disclose information to identify or locate a suspect, fugitive, material witness, or missing person. In addition, we may disclose information about a crime victim or about a death we believe may be the result of criminal conduct. In emergency situations, we may disclose PHI to report a crime, to help locate the victims of the crime, or the identity/description/location of the person who committed the crime.
- **Incidental Disclosures.** Professional Hearing Center may make incidental uses and disclosures of your protected health information. Incidental uses and disclosures may result from otherwise permitted uses and disclosures and cannot be reasonably prevented. Having your name called aloud by a staff member in the waiting room is an example of an incidental disclosure.
- **Disaster Relief.** When permitted by law, we may coordinate our uses and disclosures of protected health information with other organizations authorized by law or charter to assist in disaster relief efforts. For example, a disclosure to the Red Cross or a similar organization.

IV. SPECIAL SITUATIONS

- **Military Personnel.** If you are a member of the armed forces, Professional Hearing Center may release PHI about you as required by military authorities. We may also release health information about foreign military personnel to appropriate foreign military authorities.

- **Worker's Compensation.** We may disclose health information about your work-related illness or injury to comply with Workers' Compensation laws.
- **National Security.** We may disclose PHI to authorized officials for national security purposes such as protecting the President of the United States or other persons, or conducting intelligence operations.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of law enforcement, Professional Hearing Center may release PHI about you to the correction facility or law enforcement officials. This would be necessary for the institution to provide you with health care; to protect your health and safety and the health and safety of others; or for the safety and security of the correctional institution.
- **Other Uses of Your Health Information.** You have the right to revoke the authorization at any time, provided the revocation is in writing, except if Professional Hearing Center has already taken action in reliance of your authorization.

V. YOUR RIGHTS

You have the following rights with respect to your protected health information:

Right to Request Limits on Uses and Disclosures of your PHI. You have the right to request restrictions to how Professional Hearing Center uses and discloses your PHI. Your request must be in writing and given to Professional Hearing Center.

Right to Request Confidential Communications. You have the right to request confidential communications of PHI by alternative means or at alternative locations. For example, sending information to your work address rather than to your home address, or asking that Professional Hearing Center contacts you by mail rather than telephone. To request confidential communications, you must specify these instructions in writing. You must specify where and how you wish to be contacted. Professional Hearing Center will accommodate all reasonable requests.

Right to Inspect and Obtain Copies of Your Protected Health Information. You have the right to inspect and obtain copies of protected health information used to make decisions about your care, subject to applicable law. If you request copies of your health information, Professional Hearing Center may charge a fee for copying, postage, and other supplies associated with your request.

Right to Amend Your Protected Health Information. If you believe that the protected health information we have about you is incorrect or incomplete, you may request that we amend the information. To request an amendment, you must make this request in writing to Professional Hearing Center, and specify a reason that supports your request. You are aware that Professional Hearing Center may deny this request for an amendment subject to applicable law.

The Right to Obtain a List of Disclosures. You have the right to request an "accounting of disclosures" of your protected health information.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services.

VI. FINANCIAL RESPONSIBILITY

I acknowledge and agree to the terms and conditions of this Agreement. I understand that this is a binding agreement and that I am responsible to pay for the services I receive at Professional Hearing Center in the event my insurance coverage does not cover the services. I understand that Professional Hearing Center rates do represent the Usual and Customary Rates for my geographical location, which may be higher than my insurance company's UCR.

SIGNATURES:

Name of Patient_____
Print

Name of Patient Representative_____
Print

Relationship of Patient Representative to Patient_____

Signature _____ Date _____

Witness to Signature _____ Date _____

Electronic Communication Agreement

Professional Hearing Center can provide our patients with certain types of information via e-mail and/or test messaging.

Professional Hearing Center believes strongly in protecting the privacy of our patients. We do not share the names, e-mails, and/or telephone numbers of patients with any other company or with any other patient.

In order to protect you privacy all confidential/personal information will only be sent via a secure email.

○ Professional Hearing Center can use secure email messaging to confirm my upcoming appointment and send confidential/personal medical information to my email address provided below.

Email Address:_____

○ Professional Hearing Center may send cell phone text messages to confirm upcoming appointments to my cell phone number provided below. I realize that normal text messaging rates may apply.

Cell phone number: ( )_____

○ I **DO NOT** consent to email and text message communication with Professional Hearing Center.

This release of information will remain in effect until terminated by me in writing.

Patient Signature:_____ Date_____