Hill Country Audiology Service	Ann Barsch Audiology	Clinical Audiologists
703 Hill Country Drive, Suite 102	510 S. Adams Street	Ann E. Barsch, MS
Kerrville, TX 78028	Fredericksburg, TX 78624	Eric M. Hicks, AuD
830-792-4060	830-997-5006	Jeffrey G. Sirianni, AuD
830-792-5288 (Fax)	830-990-0209 (Fax)	

NOTICE OF PRIVACY PRACTICES (HIPAA)

Purpose: This Privacy Notice is required by the Privacy Regulations stemming from the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This Privacy Notice explains to you, a patient of this practice, how your medical information may be used and disclosed, and how you can get access to your medical information.

1. OUR COMMITMENT TO YOU REGARDING MEDICAL INFORMATION

This practice is determined to protect the privacy of your medical information. In order to provide you with quality care and service, as well as comply with the law, we must create a medical record for you and document the care and services you receive at this practice. Federal law requires us to ensure the confidentiality of your medical record. This notice will explain to you which circumstances require us to use or disclose your medical information. We also describe your rights, as well as our obligations, regarding the use and disclosure of medical information.

2. WHAT THE LAW REQUIRES US TO DO

The Federal Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We have the right to:

1. Change our privacy practices and terms of this notice at any time, provided that the law permits the change.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the change.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

Following is a description of the different circumstances that may require this practice to use or disclose your medical information. For any of these circumstances, you can submit a written request restricting our use or disclosure of your medical information for treatment, payment, or healthcare operations. You may also request, in writing, that we only disclose your medical information to certain individuals responsible for your care, or the payment for your care. Legally, we are not required to agree to your request. If we do agree to honor the

written request, we then must abide by our agreement unless in those situations required by law, in emergencies, or when information is necessary to treat you. If you wish to revoke any previously written request, you may do so in writing.

4. ACKNOWLEDGMENT FORM

*** To be kept of file at Hill Country Audiology Service - please sign and return to receptionist ***

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

Name: _____

Signature: _____ Date: _____

5. PATIENT INFORMATION RELEASE

I, _____ give permission for the following person(s) to have access to my medical records from Hill Country Audiology Service.

Name	Relationship To Patient
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature: _____ Date: _____

Patient Name: _____ Date: _____

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Hearing Loss Questionnaire

1. Do you have hearing difficulties? Yes ☐ No ☐ Unsure ☐

   When did it begin/first noticed? _____ Unsure ☐

   In both ears? ☐ Right ear only? ☐ Left ear only? ☐ Unsure ☐

   Do you feel it is progressively getting worse? Yes ☐ No ☐ Unsure ☐

   Rapidly ☐ Slowly ☐ Unsure ☐

   Who notices your hearing difficulties? Self ☐ Spouse ☐ Family ☐ Friends ☐

   What do you think caused your hearing difficulties? _____

2. Do you hear more clearly out of one ear than the other? Yes ☐ No ☐

   If so, which one is best? Right ☐ Left ☐ Unsure ☐

3. Does your hearing fluctuate? Yes ☐ No ☐ Unsure ☐

   If so, In both ears? ☐ Right ear only? ☐ Left ear only? ☐ Unsure ☐

4. Have you ever had your hearing tested? Yes ☐ No ☐

   If so, when was the last time? _____

5. How do you perceive your hearing on a scale from 1 to 10?

   1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

   Poor Fair Good Excellent

6. Do you notice tinnitus (noises) in your ears? Yes ☐ No ☐

   If so, which in ear do you notice the tinnitus? Both? ☐ Right only? ☐ Left only? ☐

   How would you describe the tinnitus? _____

   Would you say the tinnitus is present all the time? ☐ just occasionally? ☐

   When present, does the level stay constant? ☐ or does it fluctuate? ☐

   Does there appear to be related symptoms? Yes ☐ No ☐ Explain _____

7. Do you have blood relatives (alive/deceased) with hearing loss? Yes ☐ No ☐ Unsure ☐

   Does this include: Mother? ☐ Father? ☐ Siblings? ☐ Grandparents? ☐

   Have any worn hearing devices? Yes ☐ No ☐ Unsure ☐

   Does there appear to be a genetic link of hearing loss? Yes ☐ No ☐ Unsure ☐

8. Have you ever worn hearing aids or used an assistive listening device? Yes ☐ No ☐

   If so, what type? _____ Purchase Date: _____

   Do you feel like you might need hearing aids? Yes ☐ No ☐ Unsure ☐

9. Do you currently experience any dizziness? Yes ☐ No ☐ Unsure ☐

If so, is the dizziness constant? ☐ occurs in episodes? ☐

If episodic, how long do the episodes last? Seconds ☐ Minutes ☐ Hours ☐ Days ☐

If episodic, how long between episodes? Hours ☐ Days ☐ Weeks ☐ Months ☐

Does changing body position tend to trigger the dizziness? Yes ☐ No ☐ Unsure ☐

How would you best describe your dizziness? _____

_____

Does the dizziness occur along with nausea? Yes ☐ No ☐

Does the dizziness occur along with the presence/increase of tinnitus? Yes ☐ No ☐

When did the dizziness begin/first noticed? _____ Unsure ☐

Do you currently receive medical care for your dizziness? Yes ☐ No ☐

10. Are you currently having any ear pain and/or drainage? Yes ☐ No ☐ Unsure ☐

Are you currently experiencing an ear infection? Yes ☐ No ☐ Unsure ☐

11. Do you have a history of ear infections? Yes ☐ No ☐ Unsure ☐

As a child? ☐ As an adult? ☐ Lifelong? ☐

12. Have you ever had surgery on your ears? Yes ☐ No ☐ Unsure ☐

Explain: _____

13. Has there been any sudden change in your hearing in the last 90 days? Yes ☐ No ☐

14. Do you have a history of cerumen (ear wax) build-up requiring removal? Yes ☐ No ☐

15. Please list the medications you take on a daily basis: _____

_____

_____

16. Have you had any significant noise exposure during your lifetime? Yes ☐ No ☐

Military ☐ Hunting/Shooting ☐ Industrial Noise ☐ Loud Music ☐ Power Tools ☐

Was hearing protection used? Always ☐ Most of the time ☐ Sometimes ☐ Never ☐

17. Have you had any of the following? (Check all that apply)

☐ High blood pressure	☐ Kidney disease	☐ Cancer
☐ Low blood pressure	☐ Stroke	☐ Radiation treatment
☐ Cardiovascular problems	☐ Diabetes	☐ Chemotherapy treatment
☐ Measles	☐ Mumps	☐ Meningitis

18. Do you have any other medical conditions what should be noted, particularly if it affects your hearing or balance?_____

_____

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Date: _____

☐ New Patient Registration

☐ Update of Current Patient

Patient Name: _____ Social Security Number: _____

Street Address: _____

City, State, Zip Code: _____ Gender: ☐ Male ☐ Female

Mailing Address (if different): _____

Date of Birth: _____ Home Phone: _____ Cell Phone: _____

E-mail Address: _____ May we contact you via e-mail: ☐ YES ☐ NO

Emergency Contact: _____ Relationship: _____ Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Name of Spouse, if appl.: _____

Primary Care Physician: _____ Referring Physician: _____

Employer: _____ Status: ☐ Full-Time ☐ Part-time ☐ Retired

Occupation: _____ Work Phone: _____

If Child, Name of School/Childcare Facility: _____

Responsible Party: _____ (Complete if Different Than Above)

Date of Birth: _____ Social Security Number: _____

Address: _____

Employer: _____ Relationship to Patient: _____

Primary Insurance - Insured's Name: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security Number: _____

Insurance Company: _____ Policy #: _____

Group #: _____

Secondary Insurance - Insured's Name: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security Number: _____

Insurance Company: _____ Policy #: _____

Group #: _____

How did you hear about our office? (Please check ALL that apply):

☐ Physician ☐ Newspaper ☐ Phonebook ☐ Friend ☐ Family Member

☐ Internet ☐ Website ☐ Other: _____

Informed Consent Agreement:

I understand that evaluation of the hearing system requires the use of specialized instrumentation. During the course of this evaluation, I understand that various earphones will be placed over or in my ears and various acoustic probes may be placed in the external ear canal. In the event amplification or other custom devices are required, I consent to placement of foam or cotton blocks in the external ear, as well as materials to make ear impressions.

Our office will file an insurance claim for any covered services that are provided. Co-payments, co-insurance, and deductibles, as well as non-covered services that are rendered, are payable at the time of your office visit unless other arrangements have been agreed upon.

If you account is referred to an attorney or collection agency, the patient or responsible party hereby agrees to pay collection fees incurred:

(Balance PLUS: 1-120 days = 54%; 120-180 days = 66%; 180+ days= 100%)

Authorization for assignment of insurance claims and release of medical records is hereby given.

I understand that I am responsible for any amount not covered by insurance.

_____ _____

Signature of Patient or Responsible Party Date

Payment types accepted are: Cash / Check / Money Order / Visa / Mastercard / Discover / American Express

2017.01.10