□HIPPA
□CA
CONFIDENTIAL INFORMATION BELONGING TO
WILLIAM LEE PARKER, Ph.D.
AND ASSOCIATES

Parker
HEARING INSTITUTE

ADULT HEARING PATIENT INFORMATION

PLEASE PRINT CLEARLY

Acct#_____

LAST _____FIRST_____MI_____

DOB____/____/____ AGE_____ SEX M/ F MARITAL STATUS □ M □ S □ W □ Other

SOCIAL SECURITY #_____

ADDRESS_____

CITY _____ STATE _____ ZIP _____

Occupation_____ Place of Employment _____Phone#_____

We confirm appointments via mobile text/email do we have your permission to contact you and leave message □ Yes □ No

MOBILE NUMBER (_____) _____

Other Number (_____) _____□HOME □WORK

EMAIL ADDRESS_____ MAY WE SEND YOU HEARING INFORMATION? YES____NO____

HOW DID YOU HEAR ABOUT US?

Primary Care Physician_____ Phone_____
□Referred By Physician _____Phone #_____
□Referred by Friend / Family:_____
□Mail □Newspaper □Promotional Call □Insurance □Yellow Pages □Internet □ Event/Health Fair □ Other_____

EMERGENCY CONTACT:

Name: _____ Relationship _____
Phone# _____

FINANCIAL INFORMATION □ Cash □ Insurance

Insurance Name_____ ID #_____ Grp#_____

Primary Subscriber Name _____

Secondary Insurance _____ID#_____Grp#_____

Primary Subscriber Name_____

ASSIGNMENT & RELEASE

I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO PARKER HEARING INSTITUTE/WILLIAM LEE PARKER PhD & ASSOCIATES INC. I AUTHORIZE THE RELEASE OF INFORMATION REQUIRED TO PROCESS THIS CLAIM. MEDICARE WILL NOT PAY FOR HEARING TESTING FOR THE SELECTION OF HEARING AIDS. I ACKNOWLEDGE THAT I BEAR ULTIMATE FINANCIAL RESPONSIBILITY FOR ALL SERVICES RENDERED REGARDLESS OF INSURANCE DISPOSITION.

SIGNED _____ DATE _____

(PATIENT)

OVER

Rev 052018

ADULT HEARING CASE HISTORY

CIRCLE YES OR NO FOR THE FOLLOWING QUESTIONS OR ANSWER ACCORDINGLY.

1.	Do you feel you have a hearing problem?	YES	NO
2.	Have you had ear drainage in the past 90 days?	YES	NO
3.	Have you noticed a sudden or progressive change in hearing in the past 90 days?	YES	NO
4.	Have you ever had a perforation of the eardrum?	YES	NO
5.	Do you have pain or feel discomfort in your ears?	YES	NO
6.	Do you have chronic or acute dizzy spells?	YES	NO
7.	Do your ears ring?	YES	NO
8.	Do you build up earwax?	YES	NO
9.	Have you ever had a head injury such as a concussion, ruptured eardrum, bleeding, etc?	YES	NO
10.	Do you have a pacemaker?	YES	NO
11.	Have you ever had ear surgery?	YES	NO
12.	If yes, when _____	ENT _____	
13.	Have you been exposed to loud noise?	YES	NO
	Were you exposed to loud noise at work?	YES	NO
14.	Are you currently or previously been involved in a lawsuit, Worker's Compensation or other legal programs involving hearing, tinnitus or dizziness?	YES	NO
15.	Is there history of hearing loss in your family? If yes, relation to you:	YES	NO
16.	Have you ever worn hearing aid (s)?	YES	NO
16b.	Are you happy with your hearing aids?	YES	NO
17.	Is it difficult to understand people on the telephone?	YES	NO
18.	Do other people complain about your hearing?	YES	NO
19.	Do you feel other people mumble often?	YES	NO
20.	Do you have trouble hearing in background noise?	YES	NO
21.	Do you avoid social situations because you have trouble hearing?	YES	NO
	What do you want us to do for you today?		

By signing below, you acknowledge that you have received and agreed to the Parker Hearing Institute Patient Privacy Policies.

_____ _____

Signature Date

10/14RV

Notice of Privacy Practices

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

This Notice of Privacy Practices describes how Parker Hearing Institute, William Lee Parker, PhD and Associates, Inc., .(Herein known as "Parker Hearing Institute") may use and disclose your Protected Health Information (PHI) to carry out treatment, payment, or support of the other healthcare operations of the practice. Your PHI is information about you contained in our records which may include your personal health history, symptoms, hearing examination results, Balance test results, hearing aids that you may be wearing, diagnoses, treatment, plans for future treatment, etc. This Notice also describes your rights to access and control your PHI. This Notice is effective as of April 14, 2003.

Uses and Disclosures of Your Protected Health Information

Treatment: Parker Hearing Institute may use your PHI to provide, coordinate, or manage your health care and any related services. For example, your Audiologist may enter your hearing examination results or balance test results into your record and determine the treatment that will work best for you. Your results may then be sent to your physician to ensure that he or she has the necessary information to treat you. We may also share your PHI with the following health professionals if necessary to improve your treatment: consulting physicians, speech therapists, school audiologists or teachers, physical therapists, special educational facilities, etc.

Payment: Parker Hearing Institute may use your PHI to obtain payment for your health care services. For example, we may contact your healthcare provider for authorization to perform services or to obtain payment for services that have been provided. Information about you may be disclosed during this process, but only as necessary.

Healthcare operations: Parker Hearing Institute may use your PHI in order to support the daily operations of the office. For example, we may use your PHI to assess the quality of care during your visit and make changes to improve the quality and effectiveness of the services we provide. We will share some of your PHI with our business associates (such as hearing aid manufacturers, earmold laboratories, warranty companies, etc.) as necessary.

Any other uses and disclosures of your PHI will not be made without your specific authorization, unless required by law. You may revoke this authorization in writing, at any time, if you wish to do so.

Your rights

- You have the right to view and obtain copies of your PHI. However, Federal Law limits your access to certain information including: information obtained under a promise of confidentiality, information related to legal proceedings, psychotherapy notes, etc.
- You have the right to request an amendment to your PHI. You may request an amendment if you feel that the information in your records is incomplete or incorrect. If your request is denied, you have the right to submit a written statement of your disagreement with the decision and it will be included in your records.
- You have the right to obtain an accounting of disclosures of your PHI.
- You have the right to request restrictions on the certain use and disclosure of your PHI. This means that you may ask us not to use or disclose your PHI to certain parties including family members, friends, or other people involved in your care. However, it is not required under Federal Law that our practice agree to a requested restriction.
- You have the right to request confidential communications of your PHI.
- You have the right to obtain a paper copy of this Notice of Privacy Practices upon request.

Our Responsibilities

- We will take every step necessary to maintain the privacy of your PHI.
- We will not use or disclose your PHI in any manner that is not consistent with the terms of this agreement.
- We will notify you if we are unable to agree to a request to restrict the use and disclosure of your PHI.
- We will provide you with this Notice of Privacy Practices explaining our legal duties under the HIPAA Privacy Act and your rights to access and control your PHI.
- We will do our best to accommodate your reasonable requests regarding the privacy of your PHI.
- We are responsible for retaining records of your PHI in accordance with the law and our record retention policy.

Complaints

If you feel that your privacy rights have been violated by our practice, you may file a complaint with our Privacy Officer or with the Secretary of Health and Human Services (HHS). We will not retaliate against you for making a complaint.

For More Information

If you have any questions regarding this Notice of Privacy Practices or if you would like to obtain additional information, please contact our Privacy Officer at (310) 540-4327.

How may we release medical/financial information?

☐Email_____ **☐ Phone**_____

☐Person_____

Your signature below is only acknowledgement that you have been presented with this Notice of Privacy Practices.

We have a cancellation policy fee of $25.00 for notices made 24 hrs or less

Patient Name (Please Print)	Patient/or Guardian Signature	Date