Parker
HEARING INSTITUTE

Confidential Information Belonging to
Parker Hearing Institute,
A Professional Corporation

ADULT HEARING PATIENT INFORMATION

PLEASE PRINT CLEARLY

LAST:_____ FIRST:_____ MI:_____

DOB:_____ AGE:_____ SEX: ☐M ☐F MARITAL STATUS: ☐married ☐single ☐widowed ☐other

SOCIAL SECURITY #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

We confirm appointments via mobile text/email. Do we have your permission to contact you and leave messages? ☐Yes ☐No

MOBILE/CELL PHONE NUMBER: _____

ALTERNATIVE PHONE NUMBER: _____ ☐HOME ☐WORK

EMAIL ADDRESS: _____ *May we send you hearing information?* ☐Yes ☐No

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

OCCUPATION: _____ PLACE OF EMPLOYMENT: _____ PHONE #: _____

HOW DID YOU HEAR ABOUT US?

☐ Referred by Care Physician: _____ PHONE #: _____

☐ Referred by Friend/Family: _____ PHONE #: _____

☐Mail ☐Newspaper ☐Promotional Call ☐Insurance ☐Yellow Pages ☐Internet ☐Event/Health Fair ☐Other: _____

EMERGENCY CONTACT/RESPONSIBLE PARTY:

NAME: _____ RELATIONSIP: _____

PHONE #: _____ ADDRESS: _____ CITY: _____ ZIP: _____

FINANCIAL INFORMATION: ☐Cash ☐Insurance

PRIMARY INSURANCE:_____ ID #: _____ GROUP #:_____

PRIMARY SUBSRIBER: _____ DOB: _____

SECONDARY INSURANCE:_____ ID #: _____ GROUP #:_____

SECONDARY SUBSRIBER: _____ DOB: _____

ASSIGNMENT & RELEASE

I ACKNOWLEDGE THE INFORMATION PROVIDED IS CORRECT. I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO PARKER HEARING INSTITUTE APC. I AUTHORIZE THE RELEASE OF INFORMATION REQUIRED TO PROCESS THIS CLAIM. I ACKNOWLEDGE THAT I BEAR ULTIMATE FINANCIAL RESPONSBILITY FOR ALL SERVICES RENDERED REGARDLESS OF INSURANCE DISPOSITION.
YOUR HEALTH INFORMATION, INCLUDING RECORDS, NOTICES, CONTRACTS, AND DISCLSURES WILL BE MAINTAINED AS ELECTRONIC FORMAT. YOU MAY REQUEST A PAPER COPY OF YOUR INFORMATION AT ANY TIME.

SIGNED _____ DATE _____
(PATIENT/RESPONSIBLE PARTY)

PATIENT NAME _____ DOB _____

ADULT HEARING CASE HISTORY

PLEASE MARK 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 rings?	☐ 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
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 a history of hearing loss in your family?	☐ YES ☐ NO
16	If yes, what relation to you?	
17	Have you ever worn hearing aid(s)?	☐ YES ☐ NO
18	If yes, are you happy with your hearing aid(s)?	☐ YES ☐ NO
19	Is it difficult to understand people on the telephone?	☐ YES ☐ NO
20	Do other people complain about your hearing?	☐ YES ☐ NO
21	Do you feel other people mumble often?	☐ YES ☐ NO
22	Do you have trouble hearing in background noise?	☐ YES ☐ NO
23	Do you avoid social situations because you have trouble hearing?	☐ YES ☐ NO
24	What do you want us to do for you today?	

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, A Professional Corporation. (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.

Notice of No Show/Cancelation Policy

We have a cancellation policy fee of $75.00 for notices made 24 hours or less.

If you call after hours, please leave a voicemail.

Your signature below is only acknowledgement that you have been presented with this Notice of Privacy Practices and No Show/Cancelation Policy.

Patient Name (please print)	Patient/Legally Responsible Party Signature	Date

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Assignment of Benefits

Financial Responsibility

- **a.** As a courtesy, we may verify coverage specifics with your insurance company. Please understand that these verifications are NOT a guarantee of coverage payment.
- **b.** I understand and agree that I am responsible to pay *Parker Hearing Institute A Professional Corporation* (herein known as "Parker Hearing") for any co-payment on the day of my first office visit, as well as any deductibles, coinsurance or amount in excess of insurance benefits.
- **a.** I understand and agree that if any payments made by the insurance plan to *Parker Hearing* exceed the expected payment amount so that is an overpayment, I will be notified and offered a refund, not to exceed the amount I have paid.

Assignment of Benefits

- **a.** I hereby authorize my Medicare and/or medical insurance benefits to be paid directly to *Parker Hearing,* separately from other facility or professional bills.
- **b.** I authorize *Parker Hearing* (or its agent) to file an appeal on my behalf for any denial of payment or adverse benefit determination made by the insurance plan.
- **c.** If the insurance plan will not direct such payment to *Parker Hearing*, I agree to forward all payments which I receive, on account of covered hearing aids or services provided, that I have not yet paid for.

Authorization to Release Information

a. I authorize *Parker Hearing* to release all medical or other information about me to the Plan necessary to determine and pay any benefits under the Plan, including:
   i. Any person or entity responsible for payment for the medical services rendered to me at *Parker Hearing*, including third-party payers, self-insurers, worker's compensation carriers and government agencies or any person acting as the agent or contractor of such party responsible for payment.
   ii. Federal, State or other governmental agencies or others as required by law for reporting purposes or for purposes of determining eligibility in government sponsored benefit programs.
   iii. Any health professionals involved in my care for the purpose of facilitating the continuity of my medical care including my personal primary care physician, or any other referring physician.

b. Additionally, I authorize that my personal and medical information may be accessed and disclosed to those listed below.
   a. NAME: _____ RELATIONSHIP: _____
   b. NAME: _____ RELATIONSHIP: _____

This authorization will remain in effect until revoked by myself in writing. A photocopy of this assignment is to be considered as valid as the original.

_____	_____	_____
Patient Name (please print)	Patient/Legally Responsible Party Signature	Date

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Notice of Non-Covered Services

Patient Name: _____ Patient's Date of Birth: _____

Payer (*if different from patient*): _____

Service	Description of Service	Approximate Patient Responsibility
Cerumen Removal	Cerumen removal is the extraction of cerumen, or earwax, from the ear canal. This service is billed per ear.	$107 per ear
Out of warranty hearing aid cleanings	If your hearing aids are out of the in-office service warranty, there will be a cleaning fee.	$16 - $165
Out of warranty hearing aid repair	If your hearing aids are out of the manufacturer warranty, there will be a fee to send the aid(s) out for repair.	$350 - $500
Hearing aid demo	To loan a set of hearing aids and try them for two weeks.	$375
Non-covered hearing aid purchase	Please check with your insurance provider if you have a hearing aid benefit. If not, the payer is responsible for the cost of new hearing aids.	Varies by device
Non-covered hearing aid services	If your hearing aids are out of the in-office service warranty, there will be a fee to adjust or repair the aid(s).	$400/hour (*billed in 15-minute increments*)
Non-covered hearing aid electroacoustic verification services	If your hearing aids are out of the in-office service warranty, there will be a fee to check the aid(s).	$400/hour (*billed in 15-minute increments*)
Non-covered diagnostics	Uncovered diagnostic procedures, or special procedure testing during a hearing test.	Varies by exam

The purpose of this form is to notify patients of services not covered by insurance policies. Please read the statements below regarding the non-covered services and then **sign the document**.

I understand that the listed services are outside the benefit range of my insurance policy, therefore my insurance provider will not pay for these services if rendered. I can inquire more about these services and the warranties related to them at any time.

I understand that this document is NOT an agreement to have any of these services rendered. These services, however, can be obtained at *Parker Hearing Institute, A Professional Corporation* at my discretion.

I understand that if I choose to have any of these services rendered, I will be responsible for the billed amount. I am freely able to inquire about the potential billed amount before the services are rendered.

By signing this document, I am acknowledging that I have read and understood the statements above.

_____

Patient/Legally Responsible Party Signature