Arizona Hearing SPECIALISTS

Hearing Health Assessment - Hearing Aid Users

Patient Name _____ Date _____

Medical History

Reason for today's appointment _____

Allergies to any medication, plastics etc.? _____

Current Medications *(Please Complete the Attached Prescription Medication List)*

Have you ever had ear surgery? ☐ Yes ☐ No If Yes, which ear? ☐ Right ☐ Left

Type _____

Please list all major surgeries *(past 10 years)* _____

Please list any serious illnesses *(past 10 years)* _____

Are you diabetic? ☐ Yes ☐ No

Are you a smoker? ☐ Yes ☐ No Exposed to secondhand smoke? ☐ Yes ☐ No

History of cardiovascular disease? ☐ Yes ☐ No

Hearing History

When was your last hearing exam? _____ By whom? _____

What were the recommendations? _____

How long ago did you notice a decline in your hearing?

☐ Recently ☐ 1-3 years ☐ 4-6 years ☐ 7-10 years ☐ More than 10 years

Have you ever used assistive listening devices? ☐ Yes ☐ No

In which ear is your hearing the poorest? ☐ Right ☐ Left ☐ Same

Which ear do you use on the telephone? ☐ Right ☐ Left ☐ Either

Have you experienced a sudden or progressive hearing loss within the last 90 days? ☐ Right ☐ Left ☐ Both ☐ Neither

Have you experienced any drainage from your ear(s) within the last 90 days? ☐ Right ☐ Left ☐ Both ☐ Neither

Do you suffer from pain or discomfort in your ear(s)? ☐ Right ☐ Left ☐ Both ☐ Neither

Do you suffer from acute or chronic dizziness? ☐ Yes ☐ No

Is there visible congenital or traumatic deformity of the ear? ☐ Yes ☐ No

Do you experience tinnitus (ringing in the ears)? ☐ Yes ☐ No

Describe _____

Any history of ear infections? ☐ Yes ☐ No

Are there any other members of your family who have a hearing problem? ☐ Yes ☐ No

Are you now or have you ever worked in a noisy place? ☐ Yes ☐ No

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Current Hearing Technology

Brand and model of your hearing technology

Style of technology ☐ Behind the Ear ☐ In the Ear

Do you use technology in both ears? ☐ Yes ☐ No

How many years ago did you purchase your technology? ☐ 1-3 ☐ 3-5 ☐ 5+

My current hearing technology performance is satisfactory

	Always	Sometimes	Never		Always	Sometimes	Never
While in background noise	1	2	3	In a restaurant	1	2	3
At religious service	1	2	3	While listening to music	1	2	3
At the movies	1	2	3	While watching TV	1	2	3
In the car	1	2	3	In group conversations	1	2	3
On the phone	1	2	3	In conversations with spouse	1	2	3
In a conference room	1	2	3	In conversations with children	1	2	3

Notes

Patient Information

Date:_____

First Name: _____ M.I.: _____ Last Name: _____

Preferred Name: _____ Gender: M / F Date of Birth: _____ Age: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

What is your preferred method of contact?: (*select one*) Home Phone: _____ Cell Phone: _____ Email:_____

Summer Address *(if different from above)*:

_____

HOW WERE YOU REFERRED? _____ **Primary Care Physician:** _____

Referring Physician (*if different from above):* _____

Employment Status: ❒ Full time ❒ Part time ❒ Self Employed ❒ Retired Student: ❒ Yes ❒ No

Employer: _____ Occupation:_____ School: _____

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed Is spouse a patient? ❒ Yes ❒ No

Spouse First Name: _____ Spouse M.I.: _____ Spouse Last Name: _____

Emergency Contact

Name: _____ Relationship to Patient: _____

Street: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email Address: _____

Primary Insurance

Insurance Company: _____

Insured's Relationship to Patient:_____

First/Last Name: _____ M.I.: ____

Date of Birth: _____ Gender: M / F

Employer: _____

Secondary Insurance

Insurance Company: _____

Insured's Relationship to Patient:_____

First/Last Name: _____ M.I.: ____

Date of Birth: _____ Gender: M / F

Employer: _____

☐ I give permission to Arizona Hearing Specialists, LLC, to release information, verbal and written, contained in my medical record and other related information, to my insurance company, physician, rehab nurse, case manager, attorney, employer, related healthcare providers, manufacturer's, assignees and/or beneficiaries and all other related persons.

☐ I acknowledge that I have received and reviewed the Health Insurance Portability and Accountability Act (HIPAA) policy of this office.

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

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

☐ I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to my provider or practice for services rendered. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after insurance has met its obligation.

Signature: _____ Date: _____

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Prescription Medication List

Patient Name_____Date_____

Have you used a tobacco product (cigarette, cigar, smokeless tobacco) one or more times in the past 24 months? ☐ Yes ☐ No

If yes, how often have you used a tobacco product in the last 24 months? _____

If yes, what type(s) of products have you used? _____

Medication	Dosage	Frequency	How Taken (oral, topical, injection, other)

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Name: _____ Date:_____

For the Person with Hearing Loss:

Take a moment to think about how you hearing loss affects your life. Then, complete the following:

1) List THREE listening situations where you would like to hear better.
2) Put a star ☆ next to the one that is the most important
3) Put a check mark ✓ next to the one that is least important

1. _____

2. _____

3. _____

If you need help coming up with three situations, please look at the back of this page

How much does your hearing loss affect your life? Mark an "X" on the line.

Does not affect my life — Very much affects my life

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Below are some examples of situations where you may have difficulty hearing

Conversations with 1 or 2 people in quiet

Hearing my spouse

Conversations in the car

Television

Radio

Feeling left out of conversations

Conversations with 1 or 2 people in noise

Telephone

Feeling upset or angry

Conversations with groups in quiet

Religious services

Meetings

Conversations with groups in noise

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FINANCIAL RESPONSIBILITY
ACKNOWLEDGEMENT AND AGREEMENT

Individual insurance policies vary by plan. Not all plans will cover all procedures. If, for any reason, services are denied by your insurance, you will be responsible for all charges.

We will verify with your insurance whether your plan requires a prior authorization. However, an authorization is not a guarantee of payment. It is the responsibility of the patient to know and understand your plan benefits and exclusions. If you have any questions, please contact member services through your insurance.

Please read and sign the following statement:

I have been informed by my provider that he/she believes that, in my case, my insurance may or may not deny payment for services. For the reasons stated, if my insurance denies payment, I agree to be personally and fully responsible for payment.

I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to my provider or practice for services rendered. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after insurance has met its obligation.

_____

Patient Signature

_____

Patient Printed Name

_____

Date

HIPAA Notice of Privacy Policy

Arizona Hearing Specialists
7574 North La Cholla Boulevard
Tucson, AZ 85741
Phone: (520) 742-2845
Fax: (520) 742-3881
arizonahearing.com

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, but we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. If you have any questions regarding this, please contact our office.

If you think we may have violated your privacy rights, contact our office. If your concern is not resolved, you may also submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US Department of Health and Social Services. If you choose to file a complaint, we will not retaliate in any way.

The Privacy Rule portion of the HIPAA regulations requires our practice to submit a copy of the Notice of Privacy Practices to each patient, both existing and new. If the patient refuses to sign the notice, Arizona Hearing Specialists is not obligated to treat the patient.

Our Doctors of Audiology possess the highest credentials in the hearing healthcare profession and are among the country's most experienced practitioners of hearing and diagnostic services.

Our mission is to deliver:

- Unsurpassed patient satisfaction
- Education and recommendations based on latest research
- Effective analysis and diagnosis of your hearing loss
- Customized technology solutions that are effective for your listening goals
- Ongoing investment in the most advanced processes, procedures and technologies to ensure superior results for each patient

Our practitioners understand "value" is not measured by price alone. Rather, value is related to how well we utilize our knowledge and experience to create a customized solution to meet your hearing expectations and best fit your lifestyle.

The Notice of Privacy Practices is required by the Privacy Regulations stemming from the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Notice of Privacy Practices explains how your medical information may be used/disclosed and how you can get access to your medical information.

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.

This Notice of Privacy Practices requires us to:

1. Keep your medical records private and to provide you with this notice.

2. Monitor our privacy practices and the terms of this notice routinely, ensuring our notice is effective, even for information recently obtained.

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

The following is a description of the different circumstances that may require this 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.

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3. Disclose your medical information for our healthcare operations.

4. 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 the case of an emergency. If we are unable to obtain permission, we will share only the health information directly necessary for your healthcare.

5. Disclose medical information to a medical examiner to identify a deceased person, or to determine the cause of death, or for tissue donations.

6. Medical information may be disclosed if you are military personnel, either active or a veteran, and if required by the appropriate authorities.

7. Share medical data to the public health and/or law enforcement official whose job is to prevent or control disease, injury or disability.

8. Share medical data to a representative from the Food and Drug Administration for the purpose of reporting adverse effects stemming from defective products, etc.

9. Medical information may be disclosed when necessary to comply with Workers' Compensation.

10. Medical information may be disclosed when in response to a court and/or administrative order in a lawsuit or similar proceeding.

11. Patient information will be shared for marketing purposes (e.g. testimonials, emails, etc.) only with the written permission of the patient on a case-by-case basis.

Each of our patients will be contacted personally in the event of a breach of our patient's health information. You have individual rights as part of the notice of Privacy Practices. As our patient you have the right to:

- Electronic version (or photocopies) of your medical records and/or a copy of this Notice of Privacy Practices. If you need copies, please notify the receptionist.
- Receive a list of all the times your medical information has been shared by our office or our business associates, other than treatment, payment, healthcare operations and/or other specified exceptions.
- Request we communicate with you about your medical information by different means or to different locations. This request must be made in writing to Arizona Hearing Specialists.
- 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 Arizona Hearing Specialists.
- Request a paper copy if you have received this Notice of Privacy Practices electronically. This request must be made in writing to Arizona Hearing Specialists.
- Opt-out of any communication regarding fundraising activities and/or educational opportunities.
- Request a restriction on certain disclosures to a health plan provider if the service received is paid for out-of-pocket.

Patient Signature Date

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