Advanced Hearing & Balance Center

3025 Shrine Road, Suite 490
Brunswick, GA 31520
912-267-1569

PATIENT INFORMATION

NAME _____ DATE OF BIRTH _____
FIRST MIDDLE LAST "GOES BY"

SS# _____ EMAIL _____ MARITAL STATUS _____

HOME PHONE# _____ CELL PHONE# _____ WORK# (or other) _____

ADDRESS _____

SPOUSES NAME_____ PREFERED METHOD OF CONTACT (circle one) EMAIL TEXT PHONE CALL

EMPLOYMENT INFORMATION

EMPLOYER NAME _____ TITLE _____

EMPLOYER ADDRESS _____ PHONE#_____

FINANCIAL RESPONSIBILITY, IF OTHER THAN SELF

NAME_____ RELATIONSHIP (CIRCLE): SPOUSE MOTHER FATHER OTHER_____

DOB _____ SS# _____ HOME # _____ CELL# _____WORK# _____

ADDRESS _____

EMPLOYER _____ ADDRESS _____

PRACTICE DEPOSIT FOR NO SHOW-CREDIT CARD INFORMATION OF FINANCIALLY RESPONSIBLE

NAME ON CARD _____ CARD#_____

EXPIRATION DATE _____ SECURITY CODE _____ CARD HOLDER'S SIGNATURE _____

REFERRAL INFORMATION

HOW DID YOU HEAR ABOUT US?_____ PRIMARY PHYSICIAN_____

INSURANCE INFORMATION

PRIMARY INSURANCE _____POLICY#_____GROUP#_____

INSURED'S NAME_____DOB_____SS#_____RELATIONSHIP TO PATIENT_____

SECONDARY INSURANCE_____POLICY#_____GROUP#_____

INSURED'S NAME_____DOB_____SS#_____RELATIONSHIP TO PATIENT_____

EMERGENCY CONTACT

NAME OF EMERGENCY CONTACT_____ PHONE#_____

The above information is true to the best of my knowledge. I hereby authorize my insurance company(s) to pay directly to Advanced Hearing & Balance, Inc. I authorize release of information to any insurance company or physician rendering treatment. I understand that I am financially responsible for any balance.

_____ _____
SIGNATURE OF PATIENT OR GUARDIAN IF MINOR **DATE**

Adult Hearing Health Case History Form

Name: _____**DOB:** _____

Primary Concern: _____

Do you think you have a hearing loss? ___Yes ___No

Is your hearing better in one ear versus the other? ___Yes ___No

If yes, which ear is the **better** ear? ___Right ___Left

Do you have ringing or noises in your ears? ___Yes ___No

If yes, which ear(s)? ___Right ___Left ___Both

How frequently? ___Rarely ___Occasionally ___Daily ___Constantly

Please check if you have <u>ever</u> been exposed to the following loud noises.

___Firearms ___Music ___Motorcycles ___Factory work ___Farm equipment
___Military equipment ___Explosions ___Power tools ___Heavy equipment
___Other: _____

Please check if you have experienced any of the following in the last <u>90</u> days.

___Deformity of the ear ___Ear pressure/fullness ___Excessive ear wax ___Sudden hearing loss
___Ear drainage/bleeding ___Popping sensation ___Ear pain ___Sensitivity to loud noise

Medical History *(please check if applicable)*

___Currently use tobacco products
___Used tobacco products in past
___Dizziness/balance problems
___Do you currently wear hearing devices
___History of ear infections/last one? _____
___Previous ear surgery/type? _____
___Family History of hearing loss

Please check if you or a family member has experienced any of the following:

Family	Self		Family	Self		Family	Self	
___	___	Heart disease	___	___	Chronic sinus infections	___	___	Measles
___	___	Stroke/TIA	___	___	Environmental allergies	___	___	Mumps
___	___	Diabetes	___	___	Kidney/renal problems	___	___	Meningitis
___	___	High Blood Pressure	___	___	Scarlett Fever	___	___	Cancer
___	___	Hypothyroidism	___	___	HIV/AIDS	___	___	Tuberculosis
___	___	Mental Illness	___	___	Visual Problems	___	___	Head trauma
___	___	Depression or anxiety	___	___	Hepatitis A, B or C	___	___	Asthma
___	___	Migraines/headaches	___	___	Liver problems	___	___	Bone or Joint
___	___	Loss of consciousness	___	___	Long term IV antibiotics			problems
___	___	Radiation/chemotherapy	___	___	Exposure to chemicals/solvents			

Any other medical conditions not listed? _____

_____

MEDICATION LIST

Please include all prescription and over the counter medicines
(including vitamins and any herbal supplements).

Patient:_____ **D.O.B.: _____**

NAME OF MEDICATION	DOSAGE	QUANTITY	ORDERING DR.

The above list is up to date and accurate as of:_____

_____ **_____**

Patient Signature **Doctor Signature**

Advanced Hearing & Balance Center, Inc.

3025 Shrine Road, Suite 490
Brunswick, GA 31520
Office: 912-267-1569 Fax: 912-261-8285

Patient Name: _____ AHBC Financial Agreement

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services, equipment and supplies received at Advanced Hearing & Balance Center. I am responsible for any applicable deductible, co-insurance or co-payments prior to the provision of services. Advanced Hearing & Balance Center will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each service this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. I further understand that such payment is not contingent on any insurance, settlement or judgement payment.

Advanced Hearing & Balance Center may file a claim for payment with my insurance company as required by contractual agreement. If the insurance company fails to pay Advanced Hearing & Balance Center in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to Advanced Hearing & Balance Center. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including a reasonable attorney's fee.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND OBTAIN REFERRAL

I understand that it is **my responsibility** to provided Advanced Hearing & Balance Center with a copy of my **current insurance** card. If I do not have insurance, I will be considered Private Pay (or Self pay) patient and I am financially responsible for the total amount of services, equipment and/or supplies provided. I will notify Advanced Hearing & Balance Center immediately upon any change in my insurance.

INSURANCE WAIVER AND NON-COVERED SERVICES WAIVER

I understand that if I do not have a copy of my current insurance card and I still wish to be seen. I can be seen as a "Private Pay" patient. You agree that neither Advanced Hearing & Balance Center nor you will file a claim for the visit. I will be required to pay the total cost of the visit in advance. In addition, there may be a service (including equipment or supplies) I desire, suggested or provided that is not covered under my insurance plan ("Non-Covered Services"); I understand I must pay for "Non-Covered" services. If feasible, a waiver/consent will be completed for each "Private Pay" visit or "Non-Covered Service."

ANNUAL OR ROUTINE HEARING EXAMS (Including Medicare Visits)

Annual or Routine hearing exams are not paid for by all insurance carriers. Medicare only covers hearing or diagnostic testing when deemed medically necessary with a written physician referral. Medicare will NOT cover a hearing exam for the soul purpose of obtaining a hearing device. I understand that I am responsible for payment, if the exam is not covered by insurance. I understand that any hearing exam(s) are **NOT** included in the purchase of a hearing device, this is a separate service.

CONSENT TO TREAT

I hereby consent and authorize the performance of all appropriate procedures and courses of treatment which in the judgement of my provider may be considered necessary or advisable for my diagnosis and /or treatment.

FINANCIAL POLICY FOR HEARING DEVICES AND SUPPLIES

I understand that hearing devices and supplies are a separate charge and not included in the cost of any diagnostic testing that may be required and payment in full is required at the time of purchase of any device(s) and/or supplies. I understand that Advanced Hearing & Balance Center will verify my insurance benefits regarding coverage for hearing devices and provide me with an estimate of my total financial responsibility. I understand that this is only an estimate and if I choose to proceed with hearing devices I will be financially responsible for the balance in full, regardless of what my explanation of benefits states. I also understand that any supplies and ear mold(s) are separate from the cost of the device(s).

ADDITIONAL INFORMATION

Advanced Hearing & Balance Center accepts payments in: Cash, Check, MasterCard or Visa. I understand that additional charges of $50.00 are applied to my account for any returned checks. I understand that I may also be charged for any certified letters sent to me for collection on my account and /or any collection agency fees.
In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to Advanced Hearing & Balance Center.

ASSIGNMENT OF BENEFITS

I hereby authorize and assign all payments and/or insurance benefits for services and/or equipment and supplies rendered to patient, directly to **Advanced Hearing & Balance Center, Inc**. I hereby authorize **Advanced Hearing & Balance Center, Inc**. to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance plan.

SIGNATURE

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

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

Patient's Signature: _____**Date Signed:** _____

Parent, Guardian or Legal Representative Signature:_____

PRIVACY NOTICE ACKNOWLEDGMENT

I acknowledge that I have had the opportunity to review a copy of Advanced Hearing & Balance Center's **Privacy Notice**. I understand that it is my responsibility to read this notice and notify Advanced Hearing & Balance Center in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. I understand that Advanced Hearing & Balance Center has the right to revise this Notice at any time and will post a copy of the current Notice in the office in a visible location at all times and on their website. Advance Hearing & Balance Center will provide me a copy of its most recent Notice upon my request.

I give my consent for Advanced Hearing & Balance Center to release my protected health information to the following person(s):
(example: spouse, children, or any other entity that is **NOT** required by HIPAA regulations)

_____

_____

Patient Signature: _____ **Date of Birth**: _____

Parent, Guardian, or Legal Representative Signature: _____

Advanced Hearing & Balance Center, Inc.

HIPAA 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. If you have any questions about this notice, please contact our office at (912)267-1569.

OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of protected health information (PHI)
- Give you this notice of our legal duties and privacy practices regarding health information about you.
- Follow the terms of our notice that is currently in effect.

PHI includes information that we create or receive about your past, present, or future health or condition, the provision of health care to you, or the payment for health care provided to you. In general, we may not use or share anymore PHI than is necessary to accomplish our purpose.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our Practice Administrator.

- **Treatment:** We may use and disclose PHI for your treatment and too provide you with treatment-related health care services. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.
- **Payment:** We may use and disclose PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may share PHI with your health plan to get paid for the health care services we provided to you. We may also share PHI with billing companies and companies that process our health care claims.
- **Health Care Operations:** We may use and disclose PHI for health care operation purposes. These uses and disclosures are necessary to make sure the all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the audiological care you receive is of the highest quality. We may also share information with our accountants, attorneys and others in order to make sure we are complying with the laws that affect us.

OTHER USES OF PHI

- **Reports required by law:** We may report PHI when the law requires us to give information to government agencies and law enforcement about victims' of abuse, neglect, or domestic violence; when dealing with gunshot and other wounds, or when required in a legal proceeding.
- **Public health:** We may report PHI about births, deaths, and other diseases to government officials in charge of collecting information. We may provide PHI relating to death to coroners, medical examiners, and funeral directors.
- **Health oversight:** We may report PHI to assist the government when it investigates or inspects a health care provider or organization.
- **Research:** We may use PHI in order to conduct medical research.
- **To avoid harm:** We may report PHI to law enforcement, in order to avoid a serious threat to the health or safety of a person or the public.
- **Other government functions:** We may report PHI for certain military and veterans' activities, national security and intelligence purposes, protective services for the President of the United States, or correctional facility situations.
- **Workers' compensation:** We may report PHI in order to comply with workers' compensation laws.
- **Appointment reminders and health-related benefits or services:** We may use health information to give you appointment reminders; or give you information about treatment choices or other health care services or benefits we offer.
- **Inmates or individuals in custody:** If you are an inmate of a correctional facility or under the custody of a law enforcement official, we may release health information to the facility or officer. This release would be made necessary if: 1) for the facility to provide you with health care: 2) to protect your health and safety or the health and safety of others: 3) for the safety and security of the facility.

Your Rights

You have the following rights regarding health information we have about you:

- **Your rights to requests limits on our use of PHI:** You may ask that we limit how we use and share your PHI. We will consider your request but are not legally required to agree to it. If we agree to your request, we will follow your limits, except in emergency situations. You cannot limit the uses and reports that we are legally required or allowed to make. To request a restriction, you must make your request in writing to the Practice Administrator.
- **Right to request confidential communication:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. This request must be made in writing to the Practice Administrator. Your request must specify how or where you wish to be contacted.

- **Your right to view and get a copy of your PHI:** You may view or obtain a copy of your PHI (except for mental health notes). Your request must be in writing. We will reply to your within 30 days of your request. If you request a copy of your PHI, we may charge a fee. Instead of providing the PHI you requested, we may offer to give you a summary or explanation of the PHI, as long as you agree to that and to the cost in advance.
- **Your rights to a list of the reports we have made:** You have the right to get a list of the parties to whom we have reported your PHI. The list will not include reports for treatment, payment, or health care operation; reports you have previously authorized: reports made directly to you or your family; reports made for national security purposes; reports to corrections or law enforcement personnel; or reports made before April 14,2003. We will respond to your request within 60 days. Your request must be made in writing to the Practice Administrator.
- **Your right to correct or update your PHI:** If you feel that there is a mistake in your PHI, or that important information is missing, you may request in writing a correction. Your request must include a reason for the correction/update. We will respond within 60 days of your request. We may deny your request if the PHI is, 1) correct and complete, 2) not created by us, 3) not allowed to be shared with you, or 4) not in our records. If we deny your request, we will inform you of the reason for the denial. You may then file a written statement of disagreement, or you may ask that your original request and our denial be attached to all future reports of your PHI.
  If we honor your request, we will change your PHI, inform you of the changes, and tell any others that need to know about the changes to your PHI.
- **Your right to a paper copy of this notice:** You can ask us for a copy of this notice at any time.
- **Person to contact for information about this notice or to file a complaint about our privacy practice:** If you have any questions about this notice, or wish to file a complaint about our privacy practices, or feel that we have violated your privacy rights, or disagree with a decision we made regarding access to your PHI, please contact our Practice Administrator. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Your complaint will not alter or affect the care we provide to you.
- **Effective date of this notice:** this notice is in effect as of April 14, 2003.

I have received the Advanced Hearing & Balance Center, Inc. privacy notification:

_____ _____

Print Name Date

_____

Signature