Hinderliter
HEARING SERVICES

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ M ☐ F Today's Date: _____

Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: Home _____ Cell _____ Email: _____

Primary Care Physician: _____ Physician Phone: _____

Employer: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Phone: _____ Phone #2: _____

INSURANCE INFORMATION *Please provide insurance card and personal ID to office staff for copying.*

Primary Insurance: _____ ID Number: _____

Name of Policy Holder: _____ Policy Holder's Birthdate: _____

Secondary Insurance: _____ ID Number: _____

Name of Policy Holder: _____ Policy Holder's Birthdate: _____

RESPONSIBLE PARTY

Name: _____

Relationship to patient: _____

REFERRAL SOURCE

Whom shall we thank for referring you?

☐ Physician: _____
☐ ENT Specialist: _____
☐ Other Audiologist: _____
☐ Newspaper: _____
☐ Other _____
☐ Friend _____
☐ Commercial/advertisement
☐ Mail
☐ Website

I understand that some recommended procedures carry a small amount of risk. These include complications that may occur during the taking of ear impressions or the removal of earwax from the ear canal. I understand that the audiologist will explain the procedures to me. I have read this consent and understand it.

I authorize Hinderliter Hearing to release information requested to process my claims. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Hinderliter Hearing of any changes in my health status or in the above information.

Patient Signature _____ Date _____
(Parent Signature if Minor Child)

PATIENT NAME: _____

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PATIENT HISTORY

Why have you decided to have your hearing tested today? (check all that apply)

☐ I want to be sure it's normal. ☐ My family suggested this. ☐ I feel my hearing is poor.

☐ I think I need hearing aids. ☐ My employer required it. ☐ Other: _____

Please list all situations in which you would like to hear or understand better or where you have trouble hearing?

_____

_____

_____

_____

If you were to find out through this evaluation that you could be helped by hearing instruments, are you ready for that help? ☐Y ☐N

Date of Last Hearing Exam _____ Location of Last Exam _____

Were you diagnosed with hearing loss? ☐Y ☐N Any family history of hearing loss? ☐Y ☐N

How long have you noticed hearing difficulties? ☐I don't think I have hearing loss ☐Recently ☐1-3 years ☐4-6 years ☐10+ years

Do you know what caused your hearing loss? ☐Y ☐N If yes, please describe: _____

Has your hearing loss been ☐Gradual ☐Sudden ☐Fluctuating?

Does one ear appear better than the other? ☐Y ☐N Worse ear ☐R ☐L

Have you been exposed to excessive noise? ☐Y ☐N Type of noise: _____ Did you wear ear protection?

Ear pain	☐Y ☐N	Dizziness	☐Y ☐N	High blood pressure	☐Y ☐N
Ear surgery	☐Y ☐N	Diabetes	☐Y ☐N	Ringing in ears	☐Y ☐N
Ear drainage	☐Y ☐N	Heart condition	☐Y ☐N	Chemotherapy/radiation	☐Y ☐N
Ear infections	☐Y ☐N	Blood thinner	☐Y ☐N	Kidney failure	☐Y ☐N
Allergy/sinus problems	☐Y ☐N	Head/neck injury	☐Y ☐N		

Do you now or have you ever worn hearing aids? ☐Y ☐N Which ear(s) ☐R ☐L Were you satisfied with them? ☐Y ☐N

Are you currently wearing hearing aids? ☐Y ☐N

List any medical issues/concerns: _____

_____

List major surgeries in past 10 years: _____

List any medications: _____

(include over-the-counter and _____

homeopathic) _____

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PATIENT LIFESTYLE

Do you participate or find yourself in any of the following activities/situations? (check all that apply)

☐ Watching TV ☐ Outdoor activities ☐ Concerts ☐ Worship services
☐ Exercise activities ☐ Phone calls ☐ Business meetings ☐ Group conversations
☐ Lectures ☐ Soft voice conversation ☐ Crowded/noisy places

Do you have trouble hearing in any of the following situations?

	Always	*Sometimes*	*Never*
While in background noise	☐	☐	☐
In the car	☐	☐	☐
On the phone	☐	☐	☐
In a conference room	☐	☐	☐
In a restaurant	☐	☐	☐
While listening to music	☐	☐	☐
While watching TV	☐	☐	☐
In group conversations	☐	☐	☐
In conversations with your spouse	☐	☐	☐
In conversations with women or children	☐	☐	☐

How would you describe your lifestyle?

☐ Active (frequent background noise)
☐ Casual (limited background noise)
☐ Quiet (occasional background noise)
☐ Very quiet (rare background noise)

Where would you like to hear better: _____

_____

_____

If amplification is deemed necessary, which is most important to you? *Rate the following 1-5, 5 being most important.*

_____ Visibility
_____ Ease of use
_____ Minimal amount of maintenance (e.g., change battery, change programs, cleaning)
_____ Ability to wear in most situations (e.g., theater, movies, on the phone, during exercise)
_____ Expense

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CURRENT/PAST HEARING AID EXPERIENCE

☐ NOT APPLICABLE

If you currently wear hearing aids, please rate your satisfaction of the aids' technology performance:

	Always Satisfactory	*Sometimes Satisfactory*	*Never Satisfactory*
While in background noise	☐	☐	☐
In the car	☐	☐	☐
On the phone	☐	☐	☐
In a conference room	☐	☐	☐
In a restaurant	☐	☐	☐
While listening to music	☐	☐	☐
While watching TV	☐	☐	☐
In group conversations	☐	☐	☐
In conversations with your spouse	☐	☐	☐
In conversations with women or children	☐	☐	☐

If you have worn hearing aids in the past but stopped, please described why you stopped:

_____

_____

_____

PATIENT NAME: _____

RELEASE OF MEDICAL RECORD

To ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, designated referring physician, or person of my request. I will be told of any expense to send records prior to their release.

I authorize Hinderliter Hearing Services to send my medical records to the following: _____ **(Patient Initials)**

_____

_____

INSURANCE AUTHORIZATION

I request that payment of authorized benefits be made to Hinderliter Hearing Services on my behalf for any services provided to me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company and any other third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I understand that I am responsible for and I agree to pay for all charges. _____ **(Patient Initials)**

NOTICE OF PRIVACY PRACTICES

I have received a copy of Hinderliter Hearing Services' Notice of Privacy Practices. I will be offered a copy of any amended Notice of Privacy Practices at each appointment, and the current notice will be posted in the office and on the website (if applicable). This Notice informs me how Hinderliter Hearing Services will use my health information for purposes of my treatment and payment for treatment. This Notice explains in more detail how Hinderliter Hearing Services may use and share my health information for other than treatment, payment, and health care options. Hinderliter Hearing Services will also use and share my health information as required or permitted by law. _____ **(Patient Initials)**

CONSENT TO CONTACT PATIENT

I/We authorize Hinderliter Hearing Services to:

Leave a message on my/our phone	Yes / No
Speak to a family member	Yes / No
Send me written mailings (e.g., reminder cards, newsletters, special promotions, etc.)	Yes / No
Send me email communications (e.g., reminders, newsletters, promotions, etc.)	Yes / No

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Hinderliter Hearing Services 751 Chestnut Suite 205 Birmingham, MI 48009. This authorization can be revoked at any time except to the extent that records have already been released pursuant to this release. I understand that information used or disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by federal or state law. I understand I have the right to: a) Inspect or copy the protected health information to be used or disclosed as permitted by federal law (or state law to the extent the state law provides greater access rights), and b) Refuse to sign this authorization.

_____

Patient, Parent of Minor Patient, or Legal Guardian Signature

_____

Printed Name of Parent or Guardian (if different than patient)