INNOVATIVE HEARING SERVICES OVER 30 YEARS EXPERIENCE SERVING PEDIATRICS AND ADULTS

Patient Information

Patient Name: _____

Address _____ Email _____

City _____ State _____ Zip _____

Birthdate _____ Sex: Female _____ Male _____ Marital Status: Married _____ Single ____ Other _____

Home Phone _____ Work Phone _____ Cell Phone_____

Student Status: Full Time ____ Part Time ____ None ____ Employment Status: Full Time ____ Part Time ____ None__

Primary Physician _____ Who referred you? _____

Primary Insurance Information **(if the patient is also the insured, enter "SAME" for name and address)**

Insured's Name _____ Birth date _____ Sex _____

Address _____ City _____ State _____ Zip _____

Patient Relation to Insured: Self _____ Spouse _____ Child _____ Other _____

Insured Employment Status: Full Time ____ Part Time ____ Retired _____ None _____

Insurance Name _____

Subscriber ID Number _____ Group Number _____

Secondary Insurance Information **(if the patient is also the insured, enter "SAME" for name and address)**

Insured's Name _____ Birth date _____ Sex _____

Address _____ City _____ State _____ Zip _____

Patient Relation to Insured: Self _____ Spouse _____ Child _____ Other _____

Insured Employment Status: Full Time ____ Part Time ____ Retired _____ None _____

Insurance Name _____

Subscriber ID Number _____ Group Number _____

Signature _____ Date _____

25211 Coolidge Hwy., Oak Park, MI 248 544-0560 Office 248 544-7480 Fax
www.innovtivehearingservices.com email: hearbetter1@yahoo.com

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers in my treatment)
- Obtaining payment from third party payers (e.g. My insurance company)
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of, your Notice of Privacy Practices. This privacy notice contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions.
However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I wish to be contacted in the following matter (circle all that apply)

Leave a message with detailed information YES or NO

Leave a message with call back number only YES or NO

Mail office updates (e.g. newsletter) YES or NO Printed

Patient Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

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ASSIGNMENT OF INSURANCE BENEFITS

Patients with insurance please read and sign below:
Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims or accept responsibility for negotiating claims with your insurance company. As a courtesy we will be happy to help you determine the coverage you have available.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans to Innovative Hearing Services, Inc. A photocopy of my insurance card and a copy of my driver's license are to be considered as valid as an original.

I am financially responsible for all charges whether or not paid by the above insurance. I hereby authorize Innovative Hearing Services to release all information necessary to secure the payment. If insurance pays only a portion of the bill or fails to make payment for Innovative Hearing Services, Inc. within 90 days, I will be responsible for payment of the balance in full at that time. It is my responsibility to provide Innovative Hearing Services, Inc. with a medical clearance from an Ear, Nose & Throat (ENT) doctor prior my appointment.

Patient's Name Signature Date

MEDICARE PATIENTS:

I request payment of authorized Medicare benefits to be made to Innovative Hearing Services, Inc. for any services rendered. I authorize any holder of personal medical information to be released to the Health Care Financing Administration and its agents. I also authorize the release of any information needed to determine these benefits or related services to pay the claim. If there are other insurance carriers, my signature authorizes release of information. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible for only the deductible, coinsurance and the non-covered services. Coinsurance and the deductible are based upon the charge determined by the Medicare carrier. Medicare only covers testing. If I would like Innovative Hearing Services to bill Medicare for my hearing test a prescription is required from my physician prior to my appointment. This can also be faxed by my doctor's office to Innovative Hearing Services at 248 544-7480. Medicare does not cover hearingaids.

Patient's Name Signature Date

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Patient Name:_____

PERMISSION TO RELEASE RECORDS

We provide you with important information about your hearing. We feel it is important for your physician to have this information for your medical records. By signing this form you are providing us with permission to send a copy to your physician. This release will be in effect until we receive written notice from you requesting that we no longer forward this information.

Patient / Guardian Signature:_____Date: _____

Physician or Referring Agency: _____

PERMISION TO OBTAIN RECORDS

In order to provide you with the best service possible, we may need to contact your previous audiologist or hearing aid dispenser, your physician or hearing aid manufacturer for information regarding your hearing, hearing aid, warranty, etc. This release will be in effect until we receive written notice from your requesting that we no longer obtain this information from this source.

Patient / Guardian Signature:_____Date: _____

Name: _____

Address:_____Tel: _____

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Date completed _____

Child's Full Name _____ Date of Birth: _____

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

School: _____ Grade: _____ Program: _____ District: _____

Person Completing this form: _____ Relation to child: _____

Father's Name: _____ Mother's Name: _____

Father's Phone: _____ Mother's Phone: _____

With whom does the child live? _____ # of Siblings and Ages?

_____

If adopted, at what age? _____ Location Adopted from: _____

Does your child have an educational or medical diagnosis? _____

MEDICAL INFORMATION:

Family Doctor/Pediatrician: _____ Phone: _____

Illnesses: _____ Surgeries: _____ Seizures: _____

History of Ear Infections: _____ Are there any family members with Hearing Loss? _____

Current Medications: _____ Allergies: _____

Is your child presently under the care of any doctor other than your pediatrician? Y/N

Name of Doctor: _____ Reason: _____

Name of Doctor: _____ Reason: _____

Date of last vision screening: _____ Results: _____

Date of last hearing screening: _____ Results: _____

BIRTH HISTORY:

Pregnancy:

Age of Mother during pregnancy: _____ General health of mother: _____ Length of pregnancy: _____

Delivery:

Duration of labor: _____ Type of delivery: _____ Any Difficulties during delivery:_____

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Birth weight: _____ Apgar score:_____ Oxygen: Y/N Intensive care needed: Y/N Length of Hospitalization _____

Breast fed? Y/N Bottle fed? Y/N Did baby suck readily? Y/N Tube fed? Y/N Sleeping patterns: _____

DEVELOPMENTAL HISTORY:

At what age did your child reach the following motor milestones?

Roll	_____	Reach for objects	_____	Ride a tricycle	_____
Sit	_____	Feed Self	_____	Ride a Bike	_____
Pull to stand	_____	Drink from a cup	_____	Swim	_____
Crawl	_____	Use a straw	_____	Cut with scissors	_____
Walk	_____	Use a writing utensil	_____	Toilet Train	_____

LANGUAGE SKILLS:

When did your child begin to:

Babble _____ Use First Word _____ Combine two words _____

Use complete sentences containing four words or more _____

Did speech begin and then stop? (If so, at what age?) Y/N

Is your child's ability to understand and use language equal? If not, which is better? _____

SELF CARE SKILLS: (If not independent, what help is needed for the following)

Dressing _____ Toilet _____ Bathing _____

Hygiene _____ Sleeping _____ Feeding _____

SOCIAL HISTORY:

How does your child play with other children (cooperative, leader, loner, aggressive, picked on, etc.)

_____

Does your child make friends easily? _____ Does your child need to be in control? _____

Describe any concerns about your child's social skills: _____

_____

Is your child difficult to discipline? (please explain)

_____

_____

In a few words describe your child as a(n):

Infant _____ Toddler _____ Currently _____

Is there any other information that has not been covered that may be helpful? _____

_____

_____

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