CONFIDENTIALITY FORM

I, _____ give Dr. Lindsay Shafer, permission to discuss information regarding my patient care with the following:

(Name) _____(Relationship _____)
(Name)_____ (Relationship _____)
(Name)_____ (Relationship _____)
(Name)_____ (Relationship _____)
(List more on back)

Please print the address where you would like your correspondence from our office sent if other than your home address.

_____

I give permission for the office to call my:
(____)_____ Home phone - Yes No
(____)_____ Cell phone - Yes No
(____)_____ Alternate Phone - Yes No
(circle one)

Can a confidential message be left on your answering machine or voicemail? Yes No
(circle one)

I give permission for the office to text a message to my cell phone. Yes No
(circle one)

* I am fully aware that a cell phone is not a secure and private line*

I am fully aware my health information may be transmitted by electronic transmission and/or fax transmittal.

_____ _____
Signature Date

_____
Witness

HIPAA Notice of Privacy Practices

BECKMAN AUDIOLOGY, PLLC
2501 JIMMY JOHNSON BLVD., SUITE 306
PORT ARTHUR, TEXAS 77640
(409) 722-3400

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 we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: You protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining prior approval for testing or hearing aids may require that your relevant protected health information be disclosed to the health plan for approval.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when Dr. Shafer is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a coy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 409-722-3400.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature _____ Print Name _____ Date _____

MEDICATION LIST

(Please be sure to include all over the counter medications, supplements, vitamins, etc.)

Patient Name: _____D.O.B. _____

Allergies: _____

_____

MEDICATION	DOSE	ROUTE	FREQUENCY	PRESCRIBED BY:

BECKMAN AUDIOLOGY, PLLC
INFORMATION SHEET

Date _____

Patient Name _____ Date of Birth _____ Age_____

Address _____City _____ State _____ Zip_____

Mailing address _____City _____State _____ Zip _____

Sex _____ Email address _____

Home Phone _____ Cell Phone _____ Alternate Ph # _____

Text Messaging YES NO Driver License # _____

Occupation _____ Employer _____ Work # _____

Employer's Address _____ City _____ State & Zip _____

Marital Status _____ If Married, Spouse's Name _____

Person to call In case of Emergency _____ Phone # _____

How did you learn about us _____ (or) Referred by _____

Primary Care Physician: _____

Primary Medical Insurance: _____ ID #:_____
Address: _____ Group #: _____
Secondary Medical Insurance: _____ ID #: _____
Address: _____ Group #: _____

COMPLETE THIS SECTION ONLY IF PATIENT IS A MINOR

Mother's Name: _____Date of birth:_____
Address: _____
City, State, Zip: _____ Phone: _____
S.S.#: _____ Drivers License #: _____
Employer: _____ Occupation: _____
Address: _____ Work #: _____

Father's Name: _____Date of birth:_____
Address: _____
City, State, Zip: _____ Phone: _____
S.S.#: _____ Drivers License #: _____
Employer: _____ Occupation: _____
Address: _____ Work #: _____

I hereby assign all medical benefits to which I am entitled, including Medicare, private insurance, and other plans to: Lindsay Shafer, Au.D. or Beckman Audiology, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance company. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNED _____DATE _____

RESPONSIBLE PARTY _____DATE_____

BECKMAN AUDIOLOGY, PLLC

Questionnaire for Adults

NAME _____ **DATE** _____

DATE OF BIRTH _____

Do you suspect a hearing loss? Yes No
If yes, which ear? Right Left Both

When did you first notice a problem with your hearing? _____

Have you experienced any dizziness? Yes No

Have you experienced any ear noises (tinnitus)? Yes No
If yes, which ear? Right Left Both

Are you or have you been exposed to loud noises for long periods of time? Yes No

If Yes, Check any of the following that apply:

- ☐ Served in the Military
- ☐ Noisy Work Environment
- ☐ Enjoy Hunting / Shooting
- ☐ Been Near an Explosion
- ☐ Other: _____

Have you suffered a head injury? Yes No
If yes, describe: _____

Do you have any major health problems (diabetes, cancer, stroke, heart illness, etc.) ? Yes No
If yes, describe: _____
_____

Please list your medications you are currently taking on attached sheet.
(or attach a complete list of medications, (prescription, over-the-counter, herbals, or supplements)
Please include the name, dosage, frequency, and route(by mouth, spray, IV, etc.))

Do you have any family members with hearing impairment? Yes No

Have you had any ear infections? Yes No

Have you worn a hearing aid before? Yes No
If yes, which ear? Right Left Both