

**Patient Intake Form**

Date:	Patient Name:	Preferred Name:
Patient's DOB: / /	Age: (circle):	Male Female
Patient's Mailing Address:		
Home Telephone#:	Cell Phone#:	
Work Telephone#:		
Email Address:		
Marital Status (circle):	Single	Married Separated Divorced Widow
Spouse's Name:		
Emergency Contact:	Relationship:	
Emergency Contact Telephone#:		
Employment Status(circle):	Full Time	Part Time Not Employed Retired
Name of Employer:		
Occupation:		

**Patient Insurance Billing Information:**

Name of Primary Care Provider (ex. Dr. John Doe):	
Name of Referring Provider:	
<b>Primary Insurance Carrier:</b>	<b>Member ID#</b>
Subscriber's Name:	
Mailing address if different from patient:	
<b>Secondary Insurance Carrier:</b>	<b>Member ID#</b>
Subscriber's Name:	DOB (mm/dd/yyyy):
Mailing address if different from patient:	
<b>Third Insurance Carrier:</b>	<b>Member ID#</b>
Subscriber's Name:	DOB (mm/dd/yyyy):
Mailing address if different from patient:	

# Patient History

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Name of Primary Care Physician: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

What is your primary concern today: \_\_\_\_\_  
How long have you been aware of this difficulty? \_\_\_\_\_  
Is this difficulty due to a work-related injury/exposure? YES / NO

**Do you feel your hearing is changing?** YES / NO  
• If so, do you feel it has been gradual or sudden? GRADUAL / SUDDEN  
Have you seen an Ear, Nose and Throat Physician? YES / NO  
• If so, who did you see? \_\_\_\_\_ When? \_\_\_\_\_

In which situations do you have difficulty hearing? (circle all that apply)

_____	in quiet	_____	television	_____	phone	_____	at work
_____	in background noise	_____		_____	at lectures / worship service / theater	_____	

When was your last hearing evaluation? \_\_\_\_\_

Do you currently wear hearing aids? YES / NO Make / Model: \_\_\_\_\_  
• If yes, are you satisfied with them? YES / NO If no, please explain: \_\_\_\_\_

On a scale of 0-10, how motivated are you to do something about your communication difficulty?

Not motivated at all    0    1    2    3    4    5    6    7    8    9    10    Highly Motivated

Rank the following in order of importance (1-4), if a hearing aid is recommended for you:

\_\_ Improved hearing in quiet    \_\_ Improved hearing in noise    \_\_ Expense    \_\_ Cosmetics

Do you have a history of any of the following? *If yes, please explain:*

Ring or noises in your ears?	YES / NO	_____
Dizziness or vertigo?	YES / NO	_____
Fullness / pressure in your ears?	YES / NO	_____
Ear infection or ear pain?	YES / NO	_____
Ruptured ear drum?	YES / NO	_____
Ear Surgery?	YES / NO	_____
Family members with hearing loss?	YES / NO	_____
Taking blood thinners/ aspirin?	YES / NO	_____
Head injury?	YES / NO	_____
Surgery within the past year?	YES / NO	_____
Excessive exposure to loud noise? (military, hunting, power tools, music, etc.)	YES / NO	_____

Are you in good health? YES / NO

• If no, please explain: \_\_\_\_\_

**Do you have a history of any of the following? Please check all that apply:**

- |                                       |   |                                      |   |
|---------------------------------------|---|--------------------------------------|---|
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> Head Injury/ TBI     | <input type="checkbox"/> Measels     | <input type="checkbox"/> Neurological Symptoms  |
| <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Meningitis  | <input type="checkbox"/> Scarlet Fever          |
| <input type="checkbox"/> Bell's Palsy | <input type="checkbox"/> Thyroid Discase      | <input type="checkbox"/> Mumps       | <input type="checkbox"/> Sinusitis              |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Tuberculosis           |
| <input type="checkbox"/> Diabetes     | <input type="checkbox"/> HIV/AIDS             | <input type="checkbox"/> Pneumonia   | <input type="checkbox"/> Vision Issues          |
| <input type="checkbox"/> Hepatitis    | <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> Stroke/TIA  | <input type="checkbox"/> Chronic Kidney Disease |

**Have you used a tobacco product one or more times in the past 24 months?** YES / NO

• If yes, how often have you used a tobacco product in the past 24 months? \_\_\_\_\_

• If yes, what type(s) of products have you used (cigarette, cigar, smokeless)? \_\_\_\_\_

**Have you ever experienced dizziness, unsteadiness, imbalance or vertigo?** YES / NO

• If yes, are you feeling dizzy today? YES / NO

• If yes, please describe: \_\_\_\_\_

Frequency of occurrence: \_\_\_\_\_

• If yes, is it accompanied by:      Hearing loss      Ringing or noises in your ear  
Nausea      -- -- Visual disturbances      Other: \_\_\_\_\_

**Have you fallen within the past 12 months?** YES / NO

• If yes, how many falls have you experienced in the 12 months? \_\_\_\_\_

• If you have fallen, have you been injured? YES / NO

Please describe your injury: \_\_\_\_\_

**Do you experience visual difficulties or disturbances?** YES / NO

• If yes, please describe: \_\_\_\_\_

**Do you currently take a Vitamin D supplement?** YES / NO

**Do you currently have a pacemaker?** YES / NO

Please list any prescription medications you are currently taking:

<u>Medication</u>	<u>Reason</u>	<u>Dosage</u>	<u>Frequency</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What would you like to gain from this evaluation? \_\_\_\_\_

How did you hear about our facility? \_\_\_\_\_

## Communication Assessment

For the following questions, use the scale, 0 through 10.

0 = I can't hear at all in this situation to

10 = I can hear, and I understand everything in this situation.

1. How would you rate your ability to understand when speaking with another person?

1 2 3 4 5 6 7 8 9 10

2. How would you rate your ability to understand while watching TV and in various types of entertainment? (ex. Movies, plays, concerts etc.).

1 2 3 4 5 6 7 8 9 10

3. How would you rate your ability to understand when conversing with a small group of people? (with family, co-workers, in meetings or over dinner).

1 2 3 4 5 6 7 8 9 10

4. How would you rate your ability to understand when you are in an unfavorable listening environment? (ex. noisy party with background music, riding in a car)

1 2 3 4 5 6 7 8 9 10

5. How would you rate your ability to understand, when on a land line telephone?

1 2 3 4 5 6 7 8 9 10

6. How would you rate your ability to understand on a cell phone?

1 2 3 4 5 6 7 8 9 10

## TINNITUS HANDICAP INVENTORY (THI)

**INSTRUCTIONS:** The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your tinnitus. Please answer every question. -Please do not skip any questions.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

- |   |                           |                                 |                          |
|---|---------------------------|---------------------------------|--------------------------|
| 1. Because of your tinnitus, is it difficult for you to concentrate?  | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| 2. Does the loudness of your tinnitus make it difficult for you to hear people?   | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| 3. Does your tinnitus make you angry?   | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| 4. Does your tinnitus make you feel confused?   | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| 5. Because of your tinnitus, do you feel desperate?   | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| 6. Do you complain a great deal about your tinnitus?  | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| 7. Because of your tinnitus, do you have trouble falling asleep at night?   | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| 8. Do you feel as though you cannot escape your tinnitus?   | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| 9. Does your tinnitus interfere with your ability to enjoy your social activities (such as going out to dinner, to the movies)? | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| 10. Because of your tinnitus, do you feel frustrated?   | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| 11. Because of your tinnitus, do you feel that you have a terrible disease?   | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| 12. Does your tinnitus make it difficult for you to enjoy life?   | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| 13. Does your tinnitus interfere with your job or household responsibilities?   | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| 14. Because of your tinnitus, do you find that you are often irritable?   | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| 15. Because of your tinnitus, is it difficult for you to read?  | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| 16. Does your tinnitus make you upset?  | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| 17. Do you feel that your tinnitus problem has placed stress on your relationships with members of your family and/or friends?  | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| 18. Do you find it difficult to focus your attention away from your tinnitus and on other things?                               | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| 19. Do you feel that you have no control over your tinnitus?  | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| 20. Because of your tinnitus, do you often feel tired?  | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| 21. Because of your tinnitus, do you feel depressed?  | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| 22. Does your tinnitus make you feel anxious?   | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| 23. Do you feel that you can no longer cope with your tinnitus?   | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| 24. Does your tinnitus get worse when you are under stress?   | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |
| 25. Does your tinnitus make you feel insecure?  | <input type="radio"/> Yes | <input type="radio"/> Sometimes | <input type="radio"/> No |



## Billing Authorization Form

I authorize use of Adirondack Audiology's billing documents on all my insurance submissions, release of information to all insurance companies and payment directly to Adirondack Audiology Associates. I understand that I am responsible for services received from this provider and I do permit a copy of this authorization to be used in place of the original. I authorize any holder of medical or other information about this patient to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers of any information for this or related Medicare claim. I understand it is mandatory to notify the health care provider or any other party who may be responsible for paying any treatments (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides for penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply.

Print Patient Name: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

If patient is under 18 years of age:

Print Name of Parent/Guardian: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Consent for Use and Disclosure of Protected Health Information  
Notice of Privacy Practices**

I hereby give my consent to Adirondack Audiology Associates, P.C. to use and disclose my protected health information (PHI) to carry out treatment, payment, and health care operations (TPO). I have the right to review the Notice of Privacy Practices, prior to signing this consent. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action regarding my care.

Adirondack Audiology Associates, P.C. reserves the right to revise its Privacy Notice Policy at any time. A revised copy may be obtained upon request.

I have the right to request that Adirondack Audiology Associates, P.C. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I \_\_\_\_\_ DOB: \_\_\_\_\_ acknowledge:  
Patient Name (Please Print) (MM/DD/YY)

I have received a current copy of the Notice of Privacy Practices provided by Adirondack Audiology Associates, P.C.

I give my consent to allow Adirondack Audiology Associates, P.C. to use and disclose my protected health information to carry out treatment, payment and healthcare operations.

As the patient, please list below the names and relationship of family members, friends or caregivers, who have your permission to discuss your medical history and test results. If the patient is a child under the age of 18 years of age, a parent or legal guardian signature is required.

1. \_\_\_\_\_ (relationship) Telephone# \_\_\_\_\_
2. \_\_\_\_\_ (relationship) Telephone# \_\_\_\_\_

Signature of Patient \_\_\_\_\_ Date: \_\_\_\_\_

**Patient under 18 years of age:**

Parent/Legal Guardian Name (Please Print): \_\_\_\_\_

**Consent to Treat Minor**

In the case of a patient being a minor (under the age of 18 years). I hereby give consent to provide diagnostic testing and treatment to the patient. I understand that diagnostic testing and treatment of the patient will be limited to the scope of this practice.

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **HIPAA Statement**

### **NOTICE OF PRIVACY PRACTICES**

The Notice of Privacy Practices is required by the Privacy Regulations stemming from the Health Insurance Portability and Accountability Act of 1996 (HIPAA). 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.

Our mission is to deliver:

- Effective analysis and diagnosis of your hearing loss or balance condition
  - Customized technology solutions that effectively integrate speech comprehension back into your life
  - Unsurpassed patient satisfaction
  - Excellence through continuing education
  - Ongoing investment in the most advanced processes, procedures and technology to ensure superior results for each patient
- Our practitioners understand "value" is not measured by price alone. Rather, value is about how well they utilize their knowledge and experience to create a customized solution to meet your hearing expectations and your lifestyle.

**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.

- Treatment is the provision, coordination or management of hearing health care. For example, we may use and disclose your information to consult with a third party or to refer you to other health care providers. We will get your written consent prior to making disclosures outside our practice for treatment purposes, except in emergencies.
- Payment includes the activities necessary to obtain reimbursement for the provision of hearing health care. For example, we may need to give your health plan information about treatment you received at our practice so your health plan will pay us or reimburse you for the treatment. We will get your written consent prior to making disclosures for payment purposes.
- Health care operations include the activities necessary for our practice to run its business operations. For example, we may use your information to review treatment and services and to evaluate the performance of our staff.

If you have any questions regarding our privacy practices or think we may have violated your privacy rights, please contact us at:

Keith Walsh, Au.D.  
Owner  
10 Marsett Road, Suite 3  
Shelburne, VT 05482  
Telephone#: 802-922-9545



If your concern is not resolved, you may also submit a written complaint to the US Department of Health and Human Services. If you choose to file a complaint, we will not retaliate in any way.

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. Update our privacy practices and the terms of this notice at any time, ensuring our notice is effective, even for information recently obtained
3. We reserve the right to make an important change in our privacy practices and change this notice to that effect. You may contact us to request a new copy of our notice and we will make the new notice available upon request.

The following is a description of the different circumstances that may require our 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
3. Provide treatment communications concerning treatment alternatives or other health related products or services, unless we or a business associate receive financial remuneration in exchange for the communication in which case we must receive your written authorization unless the communication is made face-to-face or involves gifts of nominal value.
4. Disclose medical information to a medical examiner to identify a deceased person or to determine the cause of death, or for tissue donations
5. Medical information may be disclosed if you are military personnel, either active or a veteran, and if required by the appropriate authorities
6. Share medical data to the public health and/or law enforcement official whose job is to prevent or control disease, injury, or disability
7. Share medical data with a representative from the Food and Drug Administration for the purpose of reporting adverse effects stemming from defective products, etc.
8. Medical information may be disclosed when necessary to comply with Workers' Compensation.
9. Medical information may be disclosed in response to a court and/or administrative order in a lawsuit or similar proceeding.
10. In order to contact you for fundraising activities supported by our practice. You have the option to opt out of receiving these communications by sending a written request to the privacy officer.
11. For marketing purposes for which our practice or our business associates may receive remuneration, for a disclosure that constitutes a sale of protected health information, and in all other situations not described in this policy your written authorization will be obtained before our practice will use or disclose your health information to third parties outside our practice. You

have the right to revoke such authorization by providing our practice with a written request to revoke the specific authorization.

12. If a use of disclosure is required by law, the disclosure will be made in compliance with the law and will be limited to such requirements. State and federal laws may be more stringent and may prohibit certain uses and disclosures identified above. When another law is more stringent than HIPAA, we will follow the more stringent requirements.
13. To business associates to perform functions on our practice's behalf, if the business associate has signed an agreement to protect the confidentiality of the information.
14. 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 case of emergency. If we are unable to obtain permission, we will share only the health information directly necessary for your health care.

You have individual rights as part of the Notice of Privacy Practices. As a patient of our practice you have the right to:

1. Request our practice to restrict uses and disclosures of your health information. However, we are not required to agree to the requested restriction unless you are requesting a restriction on the use and disclosure of your protected health information to a health plan for payment or healthcare operations and such information pertains to a healthcare item or service which you paid for in full and out of pocket. These requests should be made in writing to the address given in this Privacy Notice. In your request, you must tell us (a) what information you want to limit; (b) whether you want to limit our use, disclosure, or both, and (c) to whom you want the limits to apply.
2. Be notified upon a breach of any of your unsecured protected health information.
3. Request that we communicate with you regarding your confidential medical information by different means or to different locations. This request must be made in writing to our practice.
4. Request photocopies of your medical records on file and/or a copy of this Notice of Privacy Practices. If you need a photocopy, please notify the front office staff.
5. 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 our practice.
6. Receive a list of all the times your medical information has been shared by our office or our business associates for six years prior to the request date, other than treatment, payment, health care operations and/or other specified exception.
7. Request a paper copy if you have received this Notice of Privacy Practices electronically. This request must be made in writing to our practice.