Gateway Hearing Solutions

CONFIDENTIAL CASE HISTORY

NAME _____ DOB _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE _____ EMAIL _____

PRIMARY CARE PHYSICIAN _____
ADDRESS _____
COPY OF HEARING TEST SENT TO DOCTOR (CIRCLE) YES NO

MEDICAL HISTORY: CHECK ALL THAT APPLY

___DIABETES	___DEPRESSION/ANXIETY	___DIZZINESS
___HEART DISEASE	___LYME DISEASE	___THYROID
___HIGH BLOOD PRESSURE	___MEMORY PROBLEMS	___HEAD TRAUMA
___CANCER	___SMOKER	

OTHER MEDICAL CONDITIONS: _____
MEDICATIONS: _____
_____

HEARING HEALTH: CHECK ALL THAT APPLY

___DIFFICULTY HEARING	___ PRESSURE/FULLNESS	___EAR PAIN
___ EAR INFECTIONS	___EAR SURGERY	___ DRAINAGE
___RINGING (TINNITUS)	___NOISE EXPOSURE	___FAMILY HX OF HEARING LOSS

DO YOU CURRENTLY WEAR HEARING AIDS? _____

HAVE YOU HAD YOUR HEARING TESTED BEFORE? _____ WHEN _____
HAVE YOU FALLEN IN THE LAST YEAR? _____

WHEN CONVERSING WOULD YOU SAY YOU MISS SPEECH: CIRCLE ONE
ALWAYS GENERALLY OCCASIONALLY NEVER

DO YOU FEEL FRUSTRATED WHILE TALKING WITH FAMILY & FRIENDS? _____
DO YOU HAVE DIFFICULTY HEARING IN A RESTAURANT? _____
DO YOU HAVE TROUBLE HEARING TV? _____ ON THE PHONE? _____
DO HEARING DIFFICULTIES KEEP YOU FROM SOCIALIZING OR ATTENDING EVENTS? _____

BY SIGNING THIS FORM, I UNDERSTAND THAT I AM AUTHORIZING GATEWAY HEARING SOLUTIONS, INC TO SUBMIT TO MY HEALTH INSURANCE FOR PAYMENT OF TODAY'S TESTING. I ALSO UNDERSTAND THAT HAVING INSURANCE IS NOT A GUARANTEE OF PAYMENT AND I MAY BE LIABLE FOR THE TEST FEE IF NOT COVERED BY MY INSURANCE.

_____ DATE _____
SIGNATURE OF PATIENT OR AUTHORIZED AGENT

HIPAA Compliance Patient Consent Form

information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____