



Dear _____,

We would like to take a moment to welcome you to our office and assure you that you will receive the very best care available for your condition.

Date and time of your appointment: _____

It is important that our audiologists have comprehensive information about you prior to your appointment, so please take a few minutes to completely fill out the enclosed forms. Our financial policies are detailed in the enclosed Treatment, Consent, and Billing Agreement. **Please remember to bring all completed forms with you to your appointment.**

For your convenience we have included directions to our office. If you have any questions, please feel free to contact our office and speak with our friendly customer service staff. Our office hours are from Monday to Friday, 8:30 a.m. to 5:00 p.m.

We thank you for providing us this opportunity to serve you. We look forward to meeting you at your appointment!

***Note to our Medicare Patients – You will need to bring a prescription for audiologic evaluation and management from your family doctor. If you do not bring a script, you will be responsible for all charges incurred at this office visit. If you have any questions regarding obtaining a script, please contact our office.**

Patient Information – Adult

Full Name (circle one): Mr. Ms. Mrs. Dr. _____

How do you prefer to be addressed?: _____ Male [] Female []

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

E-mail Address: _____

What is the best way to reach you? [] Home Phone [] Cell Phone [] E-mail [] Other: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Relationship Status: _____

Accompanied by: _____ Relationship: _____

Your Occupation: _____ Employer: _____

Employer's Address: _____

Business Phone _____ Is it OK to call at work?: _____

Family Physician: _____ Phone Number: _____

How did you hear about our practice? [] Physician [] D&E Yellow Pages [] Lancaster Newspaper
[] Radio [] Website [] Google [] Verizon Yellow Pages [] Other: _____

Please list persons (family members, doctors, etc.) with whom you give us permission to discuss your health information, send reports, and schedule future appointments: _____

Health Insurance Information

Primary Insurance Company: _____

Policyholder's Name: _____ Relationship to Patient: _____

Policyholder's Date of Birth: _____ Social Sec. #: _____

Address: _____

Employer ID #: _____ Group #: _____

The above information is accurate to the best of my knowledge.

Signature of Responsible Party

Date

Treatment, Consent, and Billing Agreement

Health Insurance Portability & Accountability Act (HIPPA) Acknowledgement

Release of Information I give permission to *A&E Audiology, Inc.* to disclose all or any part of my medical and/or billing records to any insurance company, third party payor (including my employer, if applicable, for example, in worker's compensation cases), or collection agency which may be responsible for payment of *A&E Audiology, Inc.*'s charges on my behalf or for collecting unpaid balances from the responsible parties. I further authorize such disclosures to any of my other treating health care providers as needed for treatment or billing/payment purposes. *A&E Audiology, Inc.* will release information as permitted by law and/or HIPPA regulations.

Financial Responsibility In consideration of the services provided by *A&E Audiology, Inc.*, I completely understand and fully agree that I have full responsibility to pay *A&E Audiology, Inc.* for all services rendered. I hereby guarantee full payment of all charges. If my account is referred to a collection agency or attorney, I guarantee payment for all fees, costs, and interest. I also understand that the responsibility for payment may not be deferred for any reason or assigned to any other party. *A&E Audiology, Inc.* may bill my insurance(s) but I remain fully responsible for full payment. *A&E Audiology, Inc.* bills the patient if your insurance/third party does not pay within 90 days. I agree that if I bring any claim or complaint related to billing and/or my care and treatment which involves *A&E Audiology, Inc.*, its agents or employees, I will file all claims in Lancaster County, Pennsylvania.

Assignment of Insurance Benefits: I authorize *A&E Audiology, Inc.* to submit a claim to Medicare or other applicable insurance company on my behalf. I authorize payment directly to *A&E Audiology, Inc.* for *A&E Audiology, Inc.* benefits otherwise payable to me. I understand that Medicare does not cover hearing aid related services and therefore Medicare cannot be billed for any hearing aid related charges. I am financially responsible to *A&E Audiology, Inc.* for charges not covered by this authorization, considered non-payable by my insurance(s), non-referred or non-authorized. This covers both primary and secondary insurances including Medicare, Workman's Comp and Auto Insurance.

Participation in Insurance Products I understand that it is my responsibility to verify with my insurance or employer if *A&E Audiology, Inc.* participates with my insurance at the time of service. I relieve *A&E Audiology, Inc.* of any responsibility in reference to non-participation in the insurance or if my services were to be performed by another entity.

HIPPA Acknowledgement By signing below, I acknowledge that I have had access to *A&E Audiology, Inc.*'s Notice of Privacy Practices.

Authorization for Treatment and Procedures I hereby agree to and give consent to be treated by *A&E Audiology, Inc.* I understand that healthcare personnel in training may participate in or be present at various times throughout the course of my care at *A&E Audiology, Inc.* Such personnel are under the supervision of licensed audiologists. I have no objection to the involvement of students in my care and I hereby provide consent to such involvement.

We are a training facility, therefore, at times patient visits may be recorded for training purposes. Only if you do not wish to be recorded please initial here. _____

Correct information I understand that if I do not present accurate, current and complete billing/insurance information at the time of service, I agree to be responsible for any amounts relating to the bill including full payment of any amounts not covered by insurance. I relieve *A&E Audiology, Inc.* of any responsibility in the event correct information was not provided at the time of service. A copy of my insurance card (s) will be maintained to verify what was presented to *A&E Audiology, Inc.*

Signature of Responsible Party

Date

Health History (Adult)

Please check if you are experiencing:

Hearing Difficulty Balance Problem Tinnitus

Do you hear people speaking but have difficulty clearly understanding what is being said? _____

When did you first notice a hearing problem? _____ Was it gradual or sudden? _____

What do you feel caused your hearing problem?

Have you seen a physician for your hearing loss? _____ If so, whom and when?

Have you experienced any of the following (please circle one):

Family/friends notice you aren't hearing well?	Occasionally	Often	Always
Family/ friends report you have the T.V. volume too loud?	Occasionally	Often	Always
Do you ask people to repeat themselves?	Occasionally	Often	Always
Difficulty hearing on the telephone	Occasionally	Often	Always

Do any family members have hearing problems? _____ If so, whom, and at what age was it identified?

Is hearing loss causing any issues at work? Please explain:

Please indicate all the situations where you have been exposed to loud noises (circle all that apply): Work Home Hobbies Shooting guns Loud music

Please check any of the following situations where you notice hearing difficulty?

Television	[]	Radio	[]
Place of Worship	[]	At a table with 4-6 people	[]
At a table with 6+ people	[]	In noisy restaurants	[]
At a party	[]	Movies	[]

MEDICAL HISTORY

Please list all current medications or attach a list:

Have you had any of the following? Please circle all of those that apply.

<input type="checkbox"/> Ear Pain	<input type="checkbox"/> Infections	<input type="checkbox"/> Drainage	<input type="checkbox"/> Ears popping
<input type="checkbox"/> Ear surgery	<input type="checkbox"/> Ear tubes	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Ears Ringing (tinnitus)	<input type="checkbox"/> Trauma (head/ear)		
<input type="checkbox"/> Autoimmune disease (e.g. HIV or lupus)			
<input type="checkbox"/> Dizziness or unsteadiness			

List any operations _____

Other chronic illnesses _____

Any drug or other allergies _____

HEARING AID HISTORY

If through our evaluation we find that we can help you hear and understand more clearly, are you ready to be fit with hearing instruments now? _____

Please rate the following from 1 to 3 in order of importance to you (1-most important, 3-least important):

- _____ Ability to hear as well as I can
- _____ Cosmetics – whether others can see them
- _____ Price

You probably know others who use hearing instruments. What have you heard about their experiences?

Have you ever worn a hearing aid(s)? _____ If so, which ear(s)?

When and where did you purchase the present hearing aid(s)?

Have the hearing aids been satisfactory or unsatisfactory, and why?

Any other questions or comments?

For Office Use Only

Audiologist Notes:

Onset

Sudden or Gradual

Otologic issues (tinnitus, vertigo)

Noise exposure

HPD history

Family history