Patient Intake Form

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How did you hear about us? (Please check one) ☐ Internet ☐ Doctor Referral ☐ Health Insurance

☐ Friend/Patient Referral ☐ Drive-By ☐ Other_____

If a Friend or Doctor referred you, please give us their name so we may thank them!_____

Patient Name (First, Middle, Last) _____ Gender (M/F) _____

Date of Birth_____/_____/_____ Age_____ Social Security_____/_____/_____

Marital Status (Check one) ☐ Married ☐ Single ☐ Widowed ☐ Divorced Spouse Name_____

Local Address_____ Apt/Lot# _____

City_____ State_____ Zip_____

List month range at this location (Ex: Aug-Mar) _____ to _____

Home Phone_____ Cell Phone_____ Work Phone_____

Since we are concerned as much about privacy as you are, we will not share your e-mail with any entity for any reason, it will remain secured in our system. We are going to begin e-mailing reminders to our patients for appointments.
Email _____

Indicate acceptable forms of communication for correspondence (Please note we are required by law to communicate only by means designated.) (Check all that apply AND place an "X" next to the preferred phone for correspondence.)

☐ Mail ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐ All

Secondary Address_____

City_____ State_____ Zip_____

Responsible Party:

Name (First, Middle, Last)_____ Relationship to Patient_____

Address_____ Apt/Lot# _____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Primary Insurance_____ Secondary_____

Physician_____Occupation_____ Employer_____

Your signature indicates that you have read the information on this sheet, and all of the information you provided is free of errors. This will also serve as "Signature on File" for any insurance claims/third party claims or payments made on your account. I hereby authorize and request that payments under my insurance plan be made directly to Advanced Hearing Group for any services provided to me. I hereby consent to the administration and performance of all diagnostic procedures and/or treatments which in the judgment of my specialist may be considered necessary and advisable. I am entitled to a full explanation prior to any testing, procedure, or referral, and that I have the option to decline such treatment or seek further information.

_____ _____/_____/_____

Signature Date of Signature

_____ _____/_____/_____

Signature Date of Signature

ADVANCED HEARING GROUP

Pediatric Hearing Case History

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Child's Name_____ Date of Birth_____ Date_____

Yes No Did your child pass the newborn hearing screening? _____

Yes No Has your child's hearing ever been tested? If yes, by whom, when and results_____

_____

_____

Yes No Do you have any concerns about your child's hearing? If yes, explain_____

_____

_____

Yes No Has your child had ear drainage in the past 90 days?

Yes No Has your child had a history of chronic ear infections? If yes, which ear? Right Left Both

Yes No Has your child had ear surgery? If yes, when, which ear and type?_____

_____

Yes No Has your child complained of pain in the ears? If yes, which ear? Right Left Both

Yes No Does anyone in your family have hearing loss (immediate and extended) that began before the age of 30?

Yes No Does your child consistently respond to your voice?

Yes No Does your child respond to loud noises?

Yes No Does your child search to localize where sound is coming from?

Yes No Does your child respond to sounds from other rooms?

Yes No Does your child wear hearing aids? If yes, when was your child first fit? _____

Pregnancy and Birth History

Yes No Was the pregnancy abnormal in any way?

Yes No Was the delivery premature?

Yes No Any complications during delivery?

Yes No Did the mother have any illness during pregnancy?

Yes No Did the mother take any medication during pregnancy?

After birth did your child have?

Yes No Any infections requiring medication?

Yes No Require an incubator?

Yes No Any head, neck, or ear abnormalities?

Yes No Treatment for jaundice?

Yes No Feeding Problems?

Yes No Breathing difficulties?

If yes to any of the above, please explain _____

_____

_____

Medical History

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Has your child had or currently have one of the following?

	Yes	No		Yes	No
Allergies	◯	◯	Chicken Pox	◯	◯
Asthma	◯	◯	Seizures	◯	◯
Cancer	◯	◯	Hospitalization	◯	◯
Meningitis	◯	◯	Measles	◯	◯
Mumps	◯	◯	Vision Problems	◯	◯
Head Trauma/Injury	◯	◯	Kidney Problems	◯	◯

Briefly explain any you have checked _____

_____

_____

How many languages are spoken at home? _____ Which languages? _____

Any delays crawling, walking, or talking? _____

_____

_____

Communication History

◯ Yes ◯ No Do you have any concerns about your child's speech and language? If yes, explain_____

_____

_____

_____

At what age did your child say his/her first word?_____

At what age did your child put two words together? _____

◯ Yes ◯ No Does your child often use gestures when communicating?

◯ Yes ◯ No Does your child continue adding words after the first word?

◯ Yes ◯ No Does your child follow simple commands?

If your child is 2 years old or younger, how many words does he/she use?_____

_____

◯ Yes ◯ No Has your child's speech ever been evaluated? If yes, when?_____

◯ Yes ◯ No Is your child currently receiving speech therapy?

Is your child's speech understood by:

◯ Yes ◯ No Parents? ◯ Yes ◯ No Siblings? ◯ Yes ◯ No Other Adults?

Patient Privacy Notice (HIPPA)

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I certify that I have received the Notice of Privacy Practices from Advanced Hearing Group.

Our office routinely makes reminder telephone calls to confirm appointments. If we reach an answering machine, we will leave a message with our practice name and the time and date of your appointment. If you do NOT want us to leave a you a message, please contact the front desk.

Any information you send to us (pictures, stories, letters, biographies, thank-you notes, etc) becomes exclusive property of Advanced Hearing Group. We reserve the right to use non-identifying information about our clients for fundraising and promotional purposes that are directly related to our mission. Patients will not be compensated for use of this information. You may receive offers from our office by mail, e-mail, or by phone regarding services/products that may benefit you. We may or may not receive financial compensation from third party sources for marketing purposes. Patients can specifically request, in writing, that no information be used for promotional purposes; however, we are not responsible for purchased mailing list to random databases.

Signature:_____ Date of Signature: _____

Patient Financial Policy for Advanced Hearing Group

Patient agrees to pay for all portions of services rendered in full at the time the services are provided by our office.

Patient Financial Policies:

You are required to present a valid insurance card and photo identification upon request at each visit and as needed throughout your care. A social security number is needed for all patients or the patient may become self-pay.

Failure to cancel or reschedule an office service appointment within 24 hours notice may result in a $30.00 service charge.

Failure to cancel or reschedule a hearing evaluation within 24 hours notice will result in a $40.00 service charge. Failure to cancel or reschedule a VNG within a 24 hours notice will result in a $60.00 service fee. Hearing evaluations are scheduled for 1 to 1 1/2 hours and VNG's are scheduled for 2 1/2 hours. When a patient cancels on short notice, we are unable to fill that slot in an efficient amount of time, when it could have been given to another patient waiting for an opening.

If you have cancelled, rescheduled, or no showed at least three appointments within a 12 month period, we may dismiss you as a patient, as this time could have been given to another patient.

Outstanding balances over 30 days will begin accruing a 5% monthly service charge. If an insurance company has not paid within 60 days of billing, fees and any outstanding service charges are due and payable in full by the patient. Outstanding balances may be automatically applied to methods of payment on file. Patients with outstanding balances may be qualified for financing. Advanced Hearing Group uses a third part financing company which will use a 24 month billing cycle with no pre-payment penalty, subject to current company finance rates.

Health Insurance:

We bill most carriers for you if proper paperwork is provided to us. Any outstanding balances; co-payments, co-insurances, deductibles and non-covered benefits are your responsibility. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for your care. Verification of benefits is patient responsibility. Performance of diagnostic testing, regardless of outcome, and cerumen removal are non-refundable.

Non-disclosure of an active insurance policy will result in self-pay. If your secondary insurance does not cross over, it is the patient's responsibility for filing these claims. As a courtesy, we will provide you a claim form that you can then send to your insurance carrier. Any claim reversal/recoupment will result in your immediate financial responsibility. Any non-covered service will be due as service is rendered. If the patient is a dependent, the cardholder is financially responsible all balances.

Workers Compensation:

If your visit is work related, we will need the case number and carrier name prior to your visit in order to bill the worker's compensation insurance company.

Methods of Payments:

Our office accepts the following payment methods:

Cash, Personal Check, Credit Cards, and Patient Financing options for those patients who qualify.

For returned checks, we assess a $30.00 NSF charge. If not paid accordingly to these terms, the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections, patient agrees to pay all additional fees assessed in the collection of the debt. These fees include collection agency fees and attorney fees and you will be dismissed as a patient. The patient is ultimately responsible for all fees for services. Below signature will also serve as “Signature on File” for all types of collection.

Signature:_____ Date of Signature:_____

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ADVANCED HEARING GROUP

HEAR WELL. LIVE WELL.

- Hearing Tests
- Hearing Aids
- Middle Ear Testing
- Oto-Acoustic Emissions (OAE)
- Aural Rehabilitation
- Evaluation of Aural Rehabilitation
- Balance Testing (VNG/ENG)
- Ear Wax Removal
- Ear Molds
- Assistive Listening Devices (ALDs)

Consent To Release Medical Information From *Advanced Hearing Group*

Patient Name:_____

Date of Birth:_____ Social Security:_____

I hereby authorize Advanced Hearing Group to provide information and/or copies of my medical data to:

Name: _____ Attention of:_____

Address:_____ Phone:_____

Fax:_____

Patient Signature & Date:_____

Patient Phone Number:_____

MESA OFFICE
5202 E. MAIN ST
SUITE 105
MESA, AZ 85205
PHONE 480-218-1328
FAX 480-218-1330

SOUTH SCOTTSDALE OFFICE
1625 N. 87th ST.
SCOTTSDALE, AZ 85257
PHONE 480-429-0026
FAX 480-429-0028

NORTH SCOTTSDALE OFFICE
9445 E. IRONWOOD SQUARE DR
SUITE 100
SCOTTSDALE, AZ 85258
PHONE 480-429-0026
FAX 480-429-0028

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Notice of Privacy Practices
Effective Date of Notice: 02/01/2003

Advanced Hearing Group
1625 N. 87th St.
Scottsdale, AZ 85257
(480)429-0026 fax(480)429-0028

Advanced Hearing Group
5202 **E. Main St. (105)**
Mesa, AZ 85205
(480)218-1328 fax(480)218-1330

Advanced Hearing Group
9445 E. Ironwood Square Dr. (100)
Mesa, AZ 85258
(480)429-0026 fax(480)429-0028

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

General Rule

We respect our legal obligation to keep health information that identifies you private. The law obligates us to give you notice of our privacy practices.

Generally, we can only use your health information in our office/s or disclose it outside our office/s, without written permission, for purposes of treatment, payment, or healthcare operations. In most other situations, we will not use or disclose your health information unless you sign a written authorization form. In some limited situations, the law allows or requires us to disclose your health information without written authorization.

Uses or Disclosures of Health Information

Examples of how we use health information for treatment purposes:
·When we set up an appointment for you.
·When our specialist test your hearing.
·When our specialist prescribes hearing instruments or hearing devices.
We may disclose your health information outside our office for treatment purposes, for example:
·If we refer you to another specialist or clinic for services.
·If we send a prescription for hearing instruments to another professional to be fabricated.
·When we phone you to let you know that your hearing instruments or hearing device is ready to be picked up.

Sometimes we may ask for copies of your health information from another professional that you may have seen before.
We may use your health information within our office or disclose your health information outside or office for payment purposes. Some examples are:
·When our staff asks you about health or hearing care plans that you may belong to, or about other sources of payment for our services.
·When we prepare bills to send to you or your health care plan.
·When we process payment by credit card and when we try to collect unpaid amounts due.
·When bills or claims for payment are mailed, faxed, or sent by computer to you or your health plan.
·When we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due.
We use and disclose your health information for healthcare operations in a number of ways. Healthcare operations mean those administrative and managerial functions that we have to do in order to run our office. We may use or disclose your health information, for example, financial or billing audits, for internal quality assurance, for personal decisions, to enable our specialist to participate in managed care plans, for the defense of legal matters, to develop business plans, and for outside storage our records.

Appointment Reminders

We may call to remind you of scheduled appointments. We may also call to notify you of other treatments or services available at our office that might help you.

Uses and Disclosures without an Authorization

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never happen at our office at all. Such uses or disclosures are:
·A state or federal law that mandates certain health information is reported for a specific purpose.
·Public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the Food and Drug Administration regarding drugs or medical devices.
·Disclosure to governmental authorities about victims of suspected abuse, neglect or domestic violence.
·Uses and disclosures for health oversight activities, such as for licensing, audits by Medicare or Medicaid, or investigation of possible violations of healthcare laws.
·Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies.
·Disclosure for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else.
·Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aide in burial; or to organizations that handle organ or tissue donations.
·Uses or disclosures for health related research.
·Uses or disclosures to prevent a serious threat to health or safety.
·Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service.
·Disclosure relating to workers' compensation programs.
·Disclosure to business associates who perform healthcare operations for us and who agree to keep your health information private.

Other Disclosures

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We will not make any other uses or disclosures of your health information unless you sign a **written authorization form.**

You're Rights Regarding Your Health Information

The law gives you many rights regarding your health information.
·You can ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or healthcare operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to *Advanced Hearing Group* at the addresses or faxes shown at the beginning of the notice.
·You can ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using e-mail to your personal e-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to *Advanced Hearing Group* at the address or the faxes shown at the beginning of this notice.
·You can ask to see or get photocopies of your health information. By law, there are few limited situations in which we can refuse to permit access or copying. Primarily, however, you will be able to review or have a copy of your health information within 30 days of asking us. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our legal denial if one is required. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we sent you a written notice of this extension. If you want to review or get photocopies of your health information, send a written request to ***Advanced Hearing Group*** at the address or the faxes shown at the beginning of this notice.
·You can ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including reasons for amendment, to *Advanced Hearing Group* at the address or the faxes shown at the beginning of this notice.
·You can get a list of disclosures that we have made of your health information within the past six years (or a shorter period if you want),except disclosures for purposes of treatment, payment or health care operations, disclosures made in accordance with an authorization signed by you, and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent list, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law, we can have a 30-day extension of the time if we notify you of the extension in writing. If you want a list, send a written request to *Advanced Hearing Group* at the address or the faxes shown at the beginning of this notice.

Our Notice of Privacy Practices

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time in compliance with and as allowed by law. If we change this notice, the new privacy practices will apply to your health information that we already have, as well as to such information that we may generate in the future. If we change our Notice Privacy of Practices, we will post the new notice in our office and have copies available in our office.

Complaints

If you think that we have not properly respected the privacy of your health information, you are free to complain to us, by sending a written complaint to *Advanced Hearing Group* at the address or the faxes shown at the beginning of this notice. If you prefer, you can discuss your complaint in person or by phone. Complaints may be sent to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you if you make a valid complaint.

For More Information
If you want more information about our privacy practices, call or visit *Advanced Hearing Group* at the address or the faxes shown at the beginning of this notice.