Audiology Associates

Sycle # __________

Confidential Patient Information

Name: ____________________________________ DOB: ______________

Age: _________ Gender: Male ____ Female ____

Address: ____ City: ______________________

State: ________________________ Zip Code: __________________

Home #: ______________________________ Cell #: ____________________________

Email: ____

Name of primary care doctor: ____________________ Phone Number: _____________________

Employed _____ Yes _____ No Retired Name of Employer: ___________________________

How did you hear about us (circle one): TV Online Card or Brochure Social Media

Friend or Family / Name _____________________________________

Alternate Contact (optional)

*** The person listed below will be allowed to make/change appointments for you, we will also be allowed to discuss your care with them. If there are additional persons you wish to add please talk to the front desk.**

Name: ____ DOB: _________________________

Phone #: ________________________________ Relationship: ___________________________

Insurance Information

Primary: ______________________

Secondary: ____________________

Third: ________________________

SIGNED: ____ DATE: _________________

Audiology Associates

Audiology Associates

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Audiology Associates may use and disclose protected heath information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I am aware by signing this form I am authorizing Kathleen A. Romero Audiology, PC to bill my insurance carrier(s) for all professional services and for the purchase of hearing aids. I hereby authorize my insurance benefits to be paid directly to Kathleen A. Romero Audiology, PC realizing that I am responsible to pay non-covered services. I hereby authorize the release of pertinent medical information to my insurance carrier(s). I understand that I am responsible for payment of my charges regardless of insurance coverage. Payment of my estimated portion is due on the day of service unless prior arrangements have been made with Kathleen A. Romero Audiology, PC.

With my consent, Audiology Associates may call or text my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders and insurance items. They may call pertaining to my clinical care, including test results, treatment and hearing aid information.

With my consent, Audiology Associates may mail or email to my home or to other designated locations any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements and reports but not limited to this list. I have the right to request at Audiology Associates restrict how it uses or discloses my PHI to carry out TPO. However, 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 am consenting to Audiology Associates use and discloser of my PHI to carry out TPO.

I may revoke my consent in writing except, to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Audiology Associates may decline to provide treatment to me.

Privacy Notice Entitlement: I have been informed that I am entitled to a paper copy of the privacy policies of Audiology Associates and may receive one at any time upon request.

Signature of Patient or Legal Guardian: ______________________________

Patient's printed Name: ______________________________

Legal Guardian's printed name: ______________________________

Date: ______________

Dr. Kathleen A. Romero, AuD
Audiology Associates

Patient name: ___________________________ Date: _______________

Do you feel that you have some hearing loss? Yes _____ No _____
Which ear? ______________________

Do you have pain in your ears? Yes_____ No_____

Do you have a history of ear infections? Yes ____ No _____

Do you have a history of noise exposure? Yes _____ No _____

Do you have trouble with dizziness? Yes _____ No_____

Have you had sudden or rapid hearing loss in the last 90 days? Yes _____ No _____

Do you currently take any medication? Yes _____ No _____

Please list any significant medical conditions: ______________________________________

____

Have you ever had ear surgery? Yes _____ No _____

Have you ever been treated by and Ear Nose & Throat physician? Yes _____ No _____

Do you have ringing (tinnitus)? Yes ___ No ___ If YES which ear? R ___ L ___

Please rate the severity of the ringing in your ear(s): 1 2 3 4 5 6 7 8 9 10
Mild ... **Severe**

What is your hearing aid experience? (Check the box that most applies to you)

___ I have a hearing aid and use it regularly in my __Right __Left

____ I have inquired about a hearing aid at another office but did not purchase

___ I have a hearing aid, but do not use it

____ I have never used a hearing aid

___ I have tried a hearing aid, but returned it

On a scale of 1 to 10 how ready are you to do something about your hearing loss? (psychologically, emotionally, financially, etc.)

Not motivated 1 2 3 4 5 6 7 8 9 10 Very motivated

Put a **1** next to what is most important to you in purchasing a hearing aid, **2** next to the second most important, **3** next to the third and a **4** next to the least important to you.

____ Appearance
____ Cost
____ Durability/Reliability
____ Sound quality/Clarity