Audiology Associates

Sycle # _____

Confidential Patient Information

Name: _____ DOB: _____

Age: _____ Gender: _____ Male _____ Female

Address: _____ City: _____

State: _____ Zip Code: _____

Primary Care Dr. : _____ Phone #: _____

Referring Dr.: _____ Phone #: _____

Mother's Information

Name: _____ DOB: _____

Home #: _____ Cell #: _____

Email (optional): _____

Address: _____ City: _____

State: _____ Zip Code: _____

Father's Information

Name: _____ DOB: _____

Home #: _____ Cell #: _____

Email (optional): _____

Address: _____ City: _____

State: _____ Zip Code: _____

- If there are any other people who may be calling the office about this child or bringing this child in please inform the front desk.

Insurance Information

Primary: _____

Secondary: _____

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 disclose 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 Parent or Legal Guardian: _____

Patient's Printed Name: _____

Parent or Legal Guardian's printed name: _____

Date: _____

Dr. Kathleen A. Romero, AuD
Audiology Associates

CHILD CASE HISTORY

Patient name: _____

Did your child pass their new born hearing screening? Yes _____ No _____

Is there a history or ear infections? Yes_____ No_____

Is there a family history of hearing loss? Yes ____ No _____
Who? _____

Is there a history of noise exposure? Yes _____ No _____

Do you suspect hearing loss? Yes _____ No_____

Does your child report any ear pain? Yes_____ No_____

Are there speech and or language concerns? Yes _____ No _____

Is your child being seen by an Ear Nose and Throat physician? Yes _____ No _____

Please list any significant medical conditions: _____

_____

What school does your child attend? _____