



**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

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Audiology Associates may use and disclose protected health 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 disclosure 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: \_\_\_\_\_

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_ DOB: \_\_\_\_\_

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 \_\_\_\_\_

<p><b>Do you have ringing (tinnitus)?</b> Yes _____ No _____      <b>If YES which ear?</b> R _____ L _____</p> <p><b>Please rate the severity of the ringing in your ear(s):</b>    <b>1</b>   <b>2</b>   <b>3</b>   <b>4</b>   <b>5</b>   <b>6</b>   <b>7</b>   <b>8</b>   <b>9</b>   <b>10</b></p> <p style="text-align: center;">Mild <span style="float: right;">Severe</span></p>
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**What is your hearing aid experience? (Check the box that most applies to you)**

- |   |  |
|---|--|
| <input type="checkbox"/> I have a hearing aid and use it regularly in my<br>___ Right    ___ Left | <input type="checkbox"/> I have inquired about a hearing aid<br>at another office but did not purchase |
| <input type="checkbox"/> I have a hearing aid, but do not use it                                  | <input type="checkbox"/> I have never used a hearing aid   |
| <input type="checkbox"/> I have tried a hearing aid, but returned it                              |  |

<p><b>On a scale of 1 to 10 how ready are you to do something about your hearing loss? (psychologically, emotionally, financially, etc.)</b></p> <p style="text-align: center;"><b>Not motivated</b>    <b>1</b>   <b>2</b>   <b>3</b>   <b>4</b>   <b>5</b>   <b>6</b>   <b>7</b>   <b>8</b>   <b>9</b>   <b>10</b>   <b>Very motivated</b></p>
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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.

- |                                     |   |
|-------------------------------------|---|
| <input type="checkbox"/> Appearance | <input type="checkbox"/> Durability/Reliability |
| <input type="checkbox"/> Cost       | <input type="checkbox"/> Sound quality/Clarity  |