THE Hearing Center

"Hearing Aids Make Better Days"

Name _____ ***Phone*** _____

Address _____ ***Date of Birth*** _____

City _____ ***State*** _____ ***Zip*** _____

Email **(important)** _____ 2nd Phone _____

Do you live alone? Yes ☐ No ☐ Their Name? _____ What Insurance do you have? _____

MEDICAL HISTORY:

Physician's Name and Cross Streets _____

Do we have permission to share your hearing test with your physician? YES ☐ No ☐

Check all that apply:

Do you have tinnitus? (Ringing in the ears)	☐	Have you had ear surgery?	☐
Sudden hearing loss in the last 90 days?	☐	Are you diabetic?	☐
or Gradual hearing loss over years?	☐	Are you taking blood thinners?	☐
Do you have chronic vertigo?	☐	Have you had chemotherapy?	☐
Do you have pain in your ears?	☐	Do you create excessive wax?	☐
Liquid ear drainage in the last 90 days?	☐	Have your ears cleaned professionally?	☐

ABOUT YOUR HEARING:

When was you last hearing test?: Under 6 Mo. ☐ | 6Mo - 1Yr ☐ | 1Yr - 5Yr. ☐ | 5Yr & Up ☐

Have you ever worn a hearing aid/device? YES ☐ No ☐

If hearing loss is discovered, are you ready for help? YES ☐ No ☐

Check four of the following situations where you have the greatest frustrations with your hearing:

1. Conversations in a restaurant?	☐	6. Conversation in a car?	☐
2. Listening to a speaker or pastor?	☐	7. Hearing front door bell or knock?	☐
3. Conversation in a meeting?	☐	8. Sounds of traffic or city noise?	☐
4. Understanding Television?	☐	9. Loudness of sounds?	☐
5. Understanding on cellphone?	☐	10.Other _____	☐

Please Sign

Signature _____ ***Date*** _____

Optional:

How did you learn about The Hearing Center?

Who called to make your appointment?

Did any part of the marketing or appointment making cause you frustration?

What is your personal perspective of the hearing care industry?

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HIPPA Policy

Name _____ Date of Birth _____

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have review our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to revoke consent in writing at anytime and all full disclosure will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

PLEASE ANSWER THE FOLLOWING QUESTIONS

May we phone, email, or send a text to confirm appointments?	Yes	No
May we leave a message on your answering machine at your home or cell phone?	Yes	No
May we discuss hearing care options, pricing, outcomes with family or personal associates?	Yes	No

Signature _____ Date _____