Hearing Speech + Deaf Center

Patient Name:	Preferred Name:	Social Security:	Date of Birth:
Address **City** **State** **Zip Code**			
Primary Phone *PHI may be communicated	**Primary Language:**	**Sign Language Interpreter Needed?:**	
Race:	**Gender:**	**Primary email address:**	
Place of Employment, School, or Childcare:		**Parent/guardian name (for minor patients):**	
Preferred Contact Method for appointment reminders or communication: ¨ Phone call ¨ Text ¨Email			
Primary Doctor's Name:	**Office Name & Phone Number:**		
Referring Physician, if different from above:	**Office Name:**		
Do You Want Reports Sent To: Primary Referring Both Neither Initial: _____			
Primary Insurance Company:	**Policy ID #/Medicaid ID#**	**Group #**	
Primary policy Holder name/DOB:	**Secondary Policy holder DOB-if applicable:**		
Secondary Insurance Company:	**Policy ID #/Medicaid ID#**	**Group #**	

Please provide a list of any/all individuals who may obtain private/protected health information regarding the above patient. (Example: other parent, step-parent, grandparent, healthcare provider, etc.).

In compliance with: The Health Insurance Portability and Accountability Act (HIPAA) and Protected health information (**PHI**) under the US law is any information about health status, provision of health care, or payment for health care created or collected by a Covered Entity and can be linked to a specific individual.

	Name (of individual or entity) You Are Authorizing:	Relationship to Patient:	Phone #
Emergency contact:			
Other:			

How did you hear about us? Online Search/Web Newspaper Social Media Magazine Health Fair/Presentation Physician School/childcare facility Friend/family member Other: _____

PLEASE INITIAL EACH LINE AND SIGN BELOW

_____ I give my consent for Hearing Speech & Deaf Center to conduct the necessary evaluation, treatments, and/or device assistance as I have requested.

_____ I certify that I have read this Center's privacy practices (attached) and that I have had an opportunity to review this document and ask questions. I am satisfied with the explanation and am confident that the facility is committed to protecting my/my child's health information. This acknowledgement will remain in effect indefinitely unless otherwise revoked by written, dated request. The signature below will remain in effect indefinitely unless terminated by either the patient or Hearing Speech & Deaf Center of Greater Cincinnati.

_____ I have reviewed and agree to the attached financial policy. If you are not the responsible party provide their name and contact information _____

Patient/Guardian Signature: _____ Date: _____

Hearing Speech + Deaf Center

Notice of Privacy Practices

Hearing Speech and Deaf Center of Greater Cincinnati is required by law to protect the privacy of your personal health information, provide this notice about information practices and follow the information practices that are described herein.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Hearing Speech + Deaf Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). HSDC's Notice of Privacy Practices provides a more complete description of such uses and disclosures.
I have the right to review the Notice of Privacy Practices prior to signing this consent. HSDC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to HSDC's Compliance Officer at 2825 Burnet Ave. Cincinnati, OH 45219. With this consent, HSDC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my hearing or speech services. With this consent, HSDC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.
I have the right to request that HSDC 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 on page 1, I am consenting to HSDC's 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, or later revoke it, HSDC may decline to provide treatment to me.

General Consent for Care and Treatment

You have the right, as a patient, to be informed about your condition and the recommended evaluation, diagnostic and treatment procedures to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).
This consent provides us with your permission to perform reasonable and necessary evaluations, testing and treatments. By signing on page 1, you're indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any treatment ordered for you. If you have any concerns regarding any treatment recommended by your health care provider, we encourage you to ask questions.
I voluntarily request a health care provider to perform reasonable and necessary evaluation, testing and treatment for the condition which has brought me to seek care at this practice.

Agreement to Pay/Insurance Release Form

Fees are charged for the professional services rendered. You, as the responsible party, accept complete financial responsibility for payment of all services provided. You are expected to pay all deductibles, co-pays, co-insurance amounts and non-covered services at the time of service. We will bill your insurance company for all covered services. You are financially responsible for payment in full for any services that are denied as a non---covered service, not medically necessary, or if you failed to notify us of changes in insurance coverage, or if you did not obtain a referral or authorization as required by your insurance company.
You are responsible for notifying HSDC immediately of any changes in your insurance policy and for obtaining insurance related referrals and/or authorizations. If payment on a claim we submit is not received from Medicare, Medicaid, private insurance companies, or other third party payers within 90 days, you are responsible for payment of the balance in full at that time. If your insurance company makes a payment after 90 days, you will be issued a refund within 30 days of payment equal to the amount paid by the insurance company. If HSDC is a not a participating provider (out of network) with your insurance company, you are responsible for payment in full at the time of service. We will submit a claim to your insurance company on your behalf. If your insurance company makes a payment on the claim, you will be issued a refund check within 30 days of receipt of payment equal to the amount paid by the insurance company.
HSDC may release patient information to third party payers and anyone assisting us in obtaining payment, including billing, coding, and collection agents and to the provider's attorneys and consultants. HSDC reserves the right to discontinue services if you do not pay for your services, cancel appointments with less than 24 hours notice, or repeatedly no show appointments. I understand that HSDC cannot guarantee payment from participating insurance providers for services. Therefore, if my insurance carrier denies payment, I agree to be fully responsible for payment. I request that payment under my third party payer(s) be made directly to HSDC and I authorize them to submit a claim to the third party payer(s) on my behalf. I understand and agree to HSDC's policies as stated here.

Patient Behavior Expectations Policy

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Purpose:
The purpose of this policy is to outline expected behaviors for patients attending appointments with HSDC employees and guests, ensuring a safe and respectful environment for all individuals at the Hearing Speech and Deaf Center.

Policy Statement:
Patients are expected to conduct themselves in a manner that promotes a positive experience for themselves, staff, and other patients. This policy details the expectations regarding patient behavior during their appointments.

Expectations of Patient Behavior:

1. **Respectful Communication:**
   - Patients should communicate courteously with HSDC employees and guests.
   - Constructive feedback is welcome, but abusive or disrespectful language will not be tolerated.
2. **Punctuality:**
   - Patients are expected to arrive on time for their appointments. If you anticipate being late or need to reschedule, please notify the center as soon as possible.
   - Patients arriving in excess of 10 minutes late will likely have to reschedule their appointment.
3. **Confidentiality:**
   - Patients must respect the confidentiality of other patients. Discussions should not occur in shared spaces where others might overhear sensitive information.
4. **Personal Responsibility:**
   - Patients are responsible for providing accurate medical histories, financial information, and any updates concerning their health status or changes in their hearing needs.
5. **Cooperation:**
   - Patients are expected to cooperate with HSDC employees during assessments and treatments, including following instructions and participating actively in their care.
6. **Appropriate Attire:**
   - Patients should wear appropriate apparel for their appointments, keeping in mind the importance of comfort during hearing tests and evaluations.
7. **Cell Phone Use:**
   - Cell phones should be silenced or turned off during appointments to minimize distractions. If urgent calls are necessary, please step outside the consultation area.
8. **Disruption-Free Environment:**
   - Behavior that disrupts the appointment process, including loud talking, inappropriate displays of anger, or other disturbances, is not allowed.
9. **Zero Tolerance for Violence:**
   - Any form of harassment, intimidation, verbal abuse, or physical violence will result in immediate dismissal from the premises and may lead to further action.

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Non-Compliance:

Failure to adhere to these expectations may result in rescheduling of the appointment, limitation of services, or being barred from future appointments at the Hearing Speech and Deaf Center.

Conclusion:
We appreciate your cooperation in adhering to these behavior expectations. Together, we can create a supportive and respectful environment conducive to optimal hearing care.

For questions or concerns regarding this policy, please contact the Hearing Speech and Deaf Center.

By signing below, you agree that you have reviewed and understand the expectations outlined in this policy.

_____ _____/_____/_____

Patient Signature or Parent/Guardian Signature *Date*

_____

Printed Name

Received by: _____

Hearing Speech + Deaf Center

Adult Audiologic Case History Form

Name: _____ **Date:** _____

DOB: _____ **Provider:** _____

SECTION 1: MEDICAL & EAR HISTORY: Please check all boxes that apply to you.

A. Hearing History	B. Vestibular Symptoms	C. Medical Conditions	D. Prior Diagnoses
☐ Hearing loss	☐ Vertigo/Spinning	☐ Diabetes	☐ Autism
☐ Ear pain	☐ Dizziness/ Lightheaded	☐ High blood pressure	☐ ADHD
☐ Ear fullness / pressure	☐ Balance problems	☐ Stroke	☐ Down Syndrome
☐ Drainage / ear infection	☐ Falling	☐ Dementia / Alzheimer's	☐ Ehlers-Danlos
☐ Tinnitus	☐ Meniere's Disease	☐ Cancer/ Chemotherapy	☐ Dysautonomia/ POTS
☐ Noise exposure		☐ Head/Neck/Ear Surgeries	☐ Usher Syndrome
☐ Family history of hearing loss		Type…… Year……	☐ Other

SECTION 2: Please select all symptoms and options that apply to you.

1. Hearing Loss: ☐ No ☐ Yes If yes please answer the following

-Side ☐ Right ☐ Left ☐ Both

-Onset ☐ Sudden ☐ Gradual ☐ Childhood

-Course ☐ Progressive ☐ Constant ☐ Fluctuating

-Duration

Have others noticed your hearing problem? ☐ No ☐ Yes

Listening Situations That Are Most Difficult:

☐ Noisy environment ☐ Large/Reverberant room ☐ Groups/meetings ☐ Face-to-face

☐ Telephone ☐ Television ☐ Alarms ☐ Softer spoken/higher pitch voices

Have you had a Hearing Test/Evaluation before? ☐ No ☐ Yes

If yes → Where/When……

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2.	**Has hearing loss impacted daily life/work/school**	☐ No	☐ Yes
If yes	Explain:		

3.	**Tinnitus** (ex. Ringing /Buzzing):	☐ No	☐ Yes	☐ Right ear	☐ Left ear	☐ Both Ears
Describe:	☐ Constant	☐ On & off	☐ bothersome	☐ non-bothersome		
Duration/how long have you noticed:						

4.	**Hearing Aid History**	☐ No	☐ Yes	☐ Right ear	☐ Left ear	☐ Both Ears
Type/Model:		Duration:				

5.	**Have you ever been exposed to loud noise at work or recreation?**	☐ No	☐ Yes
If yes	Type:	Duration:	

6.	**Have you seen an ENT/physician before?**	☐ No	☐ Yes
If yes,	Diagnosis:		

7.	**Smoking History**	☐ No	☐ Yes
If yes	____ packs/day _____ years	If quit: ____ years ago	

8.	**Allergy History**	☐ No	☐ Yes	if yes → describe……

9. Are you interested in any of our other Services listed below

☐ Speech Therapy ☐ Occupational Therapy ☐ Not currently

Clinician Notes:

……
……
……

Hearing Speech + Deaf Center

MEDICATION LIST

Name of Medication(s):

Name_____

Date of Birth_____

Today's Date_____