Comprehensive Hearing, LLC

415 Highland Avenue
Cheshire, CT 06410
Phone: 203-272-4512
Fax: 203-272-4517

Patient Information

(Please print clearly)

DATE: _____

PATIENT'S NAME: _____ DATE OF BIRTH:_____

STREET AND NUMBER: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE #: _____ MOBILE #: _____WORK #: _____

AGE: _____ SEX: _____ PLEASE CIRCLE: SINGLE MARRIED WIDOWED DIVORCED

EMAIL ADDRESS: _____

EMPLOYER NAME: _____ OCCUPATION:_____

ADDRESS: _____

SPOUSE OR PARENT or OTHER CONTACT:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE #: _____

WHO REFERRED YOU TO OUR OFFICE? _____

NAME OF FAMILY PHYSICIAN: _____ PHONE #: _____

INSURANCE INFORMATION:

NAME OF PRIMARY INSURANCE COMPANY: _____

ID NUMBER PRIMARY INSURANCE COMPANY:_____

NAME OF SECONDARY INSURANCE COMPANY:_____

ID NUMBER OF SECONDARY INSURANCE COMPANY:_____

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I hereby authorize COMPREHENSIVE HEARING, LLC to furnish information to insurance carriers concerning my evaluation and treatment, and I hereby assign to COMPREHENSIVE HEARING, LLC all payments for audiological/hearing aid services rendered to myself for my dependents for which I have not paid. I understand that I am responsible for any amount not covered by insurance.

Signature: _____ Date: _____

Hearing History Form

Date: _____

Name: _____ Date of Birth: _____

1. What prompted your visit today? _____
2. Have you had your hearing tested before? □Yes □ No If so, Where? _____

   When? _____ Do you know the results? _____
3. Do you have a family history of hearing loss? □Yes □ No
   Explain: _____
4. Does one ear hear better than the other? □Yes □ No If so, which ear? □ Right □ Left
5. Do you have a history of loud noise exposure? □Yes □ No
6. Do you have a history of tinnitus? (Ringing/buzzing/hissing sounds in the ears)? □Yes □ No
7. Do you experience dizziness or imbalance? □Yes □ No Have you in the past? □Yes □ No
8. Have you ever experienced a sudden change in hearing? □Yes □ No
9. Do you have a history of ear infections or surgeries? □Yes □ No If so, which ear? □ Right □ Left
10. Do you experience any pain, fullness or pressure in the ears? □Yes □ No
    If so, which ear? □ Right □ Left
11. Do you have active drainage from any ear? □Yes □ No If so, which ear? □ Right □ Left
12. Do you have significant ear wax accumulation? □Yes □ No
13. Do you have a history of head injuries or ear injuries? □Yes □ No
14. Are you on any medications? □Yes □ No ***If so, please provide list to copy***
15. Have you used a tobacco product (cigarette, cigar, and smokeless tobacco) one or more in the past 24 months? □Yes □ No

    If yes, how often have you used tobacco product in the past 24 months? _____

    If yes, what type(s) of products have you used? _____

TURN OVER →

16. Please check all that apply to your medical history:

□ Diabetes	□ High Blood Pressure	□ High Cholesterol
□ Cerebral Vascular Accident (CVA)	□ Migraines	□ Sinus Infections
□ Sudden Hearing Loss	□ Tinnitus	□ TMJ
□ Heart Disease	□ Cancer	□ Dizziness

17. Which of these situations are giving you the most difficulty (check all that apply):

□ Spouse/Family Members	□ Restaurants	□ Social settings	□ Television/Radio
□ Hobbies (_____)	□ Telephone	□ Place of Worship	□ Movie Theater
□ Work (_____)	□ Meetings	□ Group Gatherings	□ Other

18. What is your experience with hearing aids? (check all that apply)

☐ I have never visited with an Audiologist to inquire about hearing aids.

☐ I have visited with an Audiologist to gather information regarding my hearing difficulties, but I have not tried or purchased.

☐ I have tried hearing aids but returned the instruments.

☐ I have hearing aids but only wear it occasionally or not at all.

☐ I have a hearing aid and wear it regularly on the □ Left ear, □ Right ear.

19. Please rank the following in terms of their importance in a hearing aid (1 through 4, with 1 being the most important):

____ Overall Sound Quality ____ Reliability ____ Style/Appearance ____ Cost

20. On a scale of 1-10, how motivated are you regarding doing something about your hearing loss? (please circle one)

1 2	3 4	5 6	7 8	9 10
Not Motivated	Somewhat Motivated	Motivated	Very Motivated	Extremely Motivated

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HIPAA Compliance Patient Consent Form

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 reviewed 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 HIPAA (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 restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

May we phone or email you to confirm appointments? YES NO

May we leave a message on your answering machine at home, work, or your cell phone? YES NO

May we send information regarding new hearing aid technology or promotions? YES NO

May we discuss your medical condition with any member of your family? YES NO

If **YES**, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

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Statement to Permit Payment of Benefits to Provider And Financial Agreement

Name: _____

Authorization to Pay Benefits: I hereby assign benefits to include major medical, private insurance and any other plan to Comprehensive Hearing, LLC. A photocopy of this assignment is to be valid as the original. I understand that I am financially responsible for all charges not covered or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure this payment. I have been informed of the payment policies of Comprehensive Hearing, LLC. *Please Note: Benefits if quoted verbally by an insurance company, are not a guarantee of payment.*

Payment Request for Medicare/Medicaid: I request that payment of authorized Medicare/Medicaid benefits be made on behalf of Comprehensive Hearing, LLC for any services furnished to me by Comprehensive Hearing, LLC. I authorize any holder of medical or other information about me to release the Medicare/Medicaid Program and its agents, any information needed to determine those benefits for related services.

Financial Agreement: In consideration of these services rendered by Comprehensive Hearing, LLC at my request and direction. I agree to pay in full any portion of the bill that is deemed to be my responsibility.

Signature of Patient: _____ Date: _____

If person-signing form is other than patient please complete the following:

Signature: _____ Date: _____

Please Print:

Relationship to Patient: i.e., legal guardian, representative, relative or friend

Name:_____
Address: _____
_____

Please give reason the patient cannot sign form:_____
_____