Audiology & Hearing Associates
Patient Information Sheet

DATE _____ REFERRED BY _____

PATIENT'S NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE ____ ZIP_____

HOME PHONE _____ CELL PHONE _____ SPOUSE NAME_____

EMAIL _____ SSN _____

PLACE OF EMPLOYMENT _____ WORK PHONE _____

FAMILY PHYSICIAN _____ PHYSICIAN PHONE NUMBER_____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE _____

Please answer the following questions:

1) Does a hearing problem cause you to feel frustrated when communicating with family members, friends, neighbors or co-workers?

   NO SOMETIMES YES

2) Do you feel handicapped by a hearing problem?

   NO SOMETIMES YES

3) Does a hearing problem cause difficulty in the movies, theaters, listening to TV or radio or out at restaurants?

   NO SOMETIMES YES

4) Does a hearing problem cause you to have arguments with family members?

   NO SOMETIMES YES

5) Do you feel that any difficulties with your hearing limits or hampers your personal or social life?

   NO SOMETIMES YES

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes the physician's office to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature for each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular form.

I hereby authorize my insurance company to pay and hereby assign directly to Audiology & Hearing Associates all benefits, if any, otherwise payable to me for services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Audiology & Hearing Associates will be credited to my account, in accordance with the above said assignment.

Signature: _____ Date: _____

(Patient, parent, legal guardian, or authorized person)

PLEASE PROVIDE THE NAME AND PHONE NUMBER OF A FRIEND OR FAMILY MEMBER THAT HAS DIFFICULTY HEARING. _____

DO YOU KNOW ANYONE WHO CURRENTLY WEARS HEARING AIDS? _____

Please turn this page over

HIPPA
Patient Privacy Information

Please list family members or other persons whom we may inform about your general medical condition, diagnosis, appointments, or other health care information.

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Can we share information about your general medical condition or appointments with your employer or school?
Yes □ No □ N/A □

Can confidential messages (i.e. appointment reminders) be left on your home answering machine or voice mail?
Yes □ No □

Can we contact you at the work phone number you have listed? Yes □ No □ N/A □

Patient Authorization for Marketing – All Products and Services

To our Patients:

From time to time, our practice would like to tell patients about products and services that we think may be of interest to them. If you would like to receive information about products and services from our practice, please complete and sign the authorization form below.

I hereby authorize the practice to use my name and address and other information about my health to provide marketing communications to me. I also authorize the practice to disclose such information to an office business associate for purposes of sending marketing communications to me.

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the practice's Privacy Official at the following address: 8019 E Market St, Howland, OH 44484.

I understand that if I revoke this authorization, my revocation will not affect any actions taken by the practice before receiving my written revocation.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

Signature of Patient or Patient's Personal Representative:

_____ Date: _____

If Personal Representative:

Print Name: _____ Relationship: _____