Swank Family Hearing

Adult Case History

Patient Name: _____
Last First MI

Preferred Name: _____ Date of Birth: _____ Pronouns: _____

Address: _____
Street City State Zip

Cellphone: _____ Home Phone: _____

Email Address: _____

Emergency Contact: _____
Name Number Relationship

Primary Care Physician: _____

Insurance Company: _____

Insurance Policy Number: _____

Social Security Number: _____

How did you hear about our clinic? _____

Please answer the following questions to the best of your ability:

1. Do you have a history (past or present) of significant medical conditions? ☐ Yes ☐ No
   If yes, list: _____

2. Are you currently or have you ever taken any of the following medications? ☐ Yes ☐ No
   _____ Pain Medication _____ Diuretics _____ Antibiotics
   _____ Blood Pressure _____ Chemotherapy
   _____ Heart Medication _____ Radiation

3. Have you seen an ear, nose and throat (ENT) doctor? ☐ Yes ☐ No
   If yes, when and who? _____

4. Do you have a history (past or present) of ear infections? ☐ Yes ☐ No
   If yes, when was the last infection? _____

5. Have you ever had any type of ear surgery? ☐ Yes ☐ No
   If yes, what type and when? _____

6. Do you have any of the following:
   Pain in your ear(s)? ☐ Yes ☐ No
   Fullness or pressure in your ear(s)? ☐ Yes ☐ No

7. Have you ever seen a doctor for wax removal? ☐ Yes ☐ No
   If yes, when? _____

8. Do you have any concerns regarding your hearing? ☐ Yes ☐ No
   If yes, when did your concerns start? _____

9. Any history of sudden or rapid loss of hearing? ☐ Yes ☐ No

10. Have you ever had your hearing tested? ☐ Yes ☐ No
    If yes, when and where? _____
    Was hearing loss found? ☐ Yes ☐ No
    Were hearing aids recommended? ☐ Yes ☐ No

11. Does one ear hear better vs. the other? ☐ Yes ☐ No
    If yes, which is your *better* ear? ☐ Right ☐ Left

12. What is your current OR *pre-retirement* occupation? _____

13. Including all past/present experiences, do you have a history of noise exposure? ☐ Yes ☐ No
    If yes, select all that apply:
    ☐ Concerts ☐ Firearm Use ☐ Heavy Equipment ☐ Power Tools
    ☐ Sirens ☐ Fireworks ☐ Sporting Events ☐ Lawn Equipment
    ☐ Motor Sports ☐ Other: _____

14. Does anyone in your family have hearing loss? ☐ Yes ☐ No
    If yes, what is your relationship? _____
    Was the cause known? ☐ Yes ☐ No
    If yes, describe: _____

15. Do you have trouble hearing in any of the following situations?
    Understanding conversation in quiet ☐ Yes ☐ No
    Hearing in groups/meetings/social gatherings ☐ Yes ☐ No
    Hearing/understanding on the telephone ☐ Yes ☐ No
    Hearing/understanding the television ☐ Yes ☐ No
    Other: _____

16. Do you feel your hearing loss causes any of the following?
    Interfering with your personal or social life ☐ Yes ☐ No
    Arguments with family or friends ☐ Yes ☐ No
    Increased stress or anxiety ☐ Yes ☐ No
    Other: _____

17. Do you have any noises in your ears (ringing, static, crickets, etc.)? ☐ Yes ☐ No
    If yes, select all that apply:
    ____ Right Ear Only ____ Low Pitch ____ Interferes with My Hearing
    ____ Left Ear Only ____ Medium Pitch ____ Causes Anxiety/Stress
    ____ Both Ears ____ High Pitch ____ Causes Depression
    ____ Intermittent ____ Pitch Changes ____ Keeps Me Up at Night
    ____ Constant ____ Worse Over Time
    ____ Other: _____

18. Do you now or have you ever worn a hearing aid? ☐ Yes ☐ No

If yes, select all that apply:

_____ Behind the Ear
_____ Custom/In the Ear
_____ Custom Earmold
_____ BAHA
_____ Cochlear Implant
_____ Other

_____ Oticon
_____ Phonak
_____ Resound
_____ Signia
_____ Starkey
_____ TruHearing

_____ Disposable Batteries
_____ Rechargeable Batteries

19. Do you experience any of the following with your current hearing aids? (Select all that apply) ☐ Yes ☐ No

_____ Sounds Are Too Soft
_____ Sounds Are Too Loud
_____ Poor Fit
_____ Other _____

_____ Feedback or Whistling
_____ Poor Battery Life
_____ Pain/Discomfort

_____ Unnatural Sound
_____ Do Not Like Appearance
_____ Frequent Repairs

20. Do you have any problems or concerns with dizziness and/or balance? ☐ Yes ☐ No

If yes, describe: _____

21. Is there anything else about your ears/hearing we should be aware of? ☐ Yes ☐ No

If yes, describe: _____

_____

22. What is your goal and/or desired outcome for your appointment today?

_____

_____

HIPAA Policies

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records:

- You can ask to see or get a copy of your health and claims records and other health information we have about you.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request.
    - We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records:

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications:

- You can ask us to contact you in a specific way (for example, by home or office phone) or to send mail to a different address.
- We will consider all reasonable requests and must say “yes” if you tell us you would be in danger if we do not.

Get a list of those with whom we’ve shared information:

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you asked whom we shared it with and why.
- We will include all the disclosures except for those about treatment, payment and health care operations, and certain other disclosures.

Choose someone to act for you:

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will ensure the person has this authority and can act for you before we take any action.

How do we typically use or share your health information?

- We use it to help manage the health care treatment you receive.
- We can share your information with professionals who are treating you.

Pay for your health services:

- We can use and disclose your health information as we pay for your health services.

Administer your plan:

- We may disclose your health information to your health plan sponsor for plan administration.

Help with public health and safety issues:

- We can share health information about you for certain situations, such as:
    - Preventing disease
    - Helping with product recalls
    - Reporting suspected abuse, neglect or domestic violence
    - Preventing or reducing a serious threat to anyone's health or safety
    - We can use or share your information for health research
    - We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
    - Addressing workers' compensation, law enforcement and other government requests
    - For law enforcement purposes or with a law enforcement official
    - With health oversight agencies for activities authorized by law
    - For special government functions such as military, national security and presidential protective services
    - Responding to lawsuits and legal actions
    - In response to a court or administrative order or in response to a subpoena

File a complaint if you feel your rights are violated:

You can complain if you feel we have violated your rights by contacting us.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave. SW, Washington, D.C. 20201, calling 1-877-696-6775 or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

We will not retaliate against you for filing a complaint.

For more information, see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and on our website, and we will mail a copy to you.

I have read and understand my HIPAA rights as outlined above. I acknowledge that I have the right to request a copy of this information and that a copy will be provided immediately.

_____ _____

Patient Signature Date

Patient Rights

According to the American Speech-Language-Hearing Association, people receiving audiology services have the right to:

1. Be treated with dignity and respect
2. Services provided without regard to race, ethnicity, gender, age, religion, national origin, sexual orientation or disability
3. Know the name and professional qualifications of the person or persons providing services
4. Personal privacy and confidentiality of information to the extent permitted by law
5. Know, in advance, the fees for services, regardless of the method of payment
6. Receive a clear explanation of evaluation results, be informed of the potential or lack of potential for improvement and express their choices of goals and methods of service delivery
7. Accept or reject services to the extent permitted by law
8. Services provided in a timely and competent manner, which includes referral to other appropriate professionals when necessary
9. Present concerns about services and be informed of procedures for seeking their resolution
10. Accept or reject participation in teaching, research or promotional activities
11. To the extent permitted by law, review information contained in their records, receive an explanation of record entries upon request and request correction of inaccurate records
12. Adequate notice of, and reasons for, discontinuation of services; an explanation of these reasons, in person, upon request; and referral to other providers if so requested

Patient Responsibilities

1. I am responsible for being considerate and treating the staff and other patients with respect; should I choose to be disrespectful, rude, belligerent, etc., Swank Family Hearing reserves the right to refuse service and refer me to another provider.
2. I am responsible (to the best of my knowledge) for providing accurate and complete information about present concerns, past illnesses, hospitalizations, medications and other information regarding my health.
3. It is my responsibility to know my insurance coverage and be aware of any referrals for services that I need; I am also responsible for getting any referrals from my primary care physician and providing a copy to Swank Family Hearing so my insurance can be billed.
4. I understand that payment is expected at the time of service, and I am fully responsible for all fees my insurance does not cover.

5. I understand if I am 10+ minutes late for my appointment, I will need to reschedule for a different day and time.
6. I understand Swank Family Hearing requires 24 hours' notice in the event of a cancellation.
    a. There is a $50.00 charge for a cancellation without 24 hours' notice, which insurance will not cover.
    b. We will review any emergencies and discuss a fee waiver on a case-by-case basis.
7. I acknowledge and understand the following policies regarding hearing aids:
    a. Wax Removal
        i. Insurance companies do not cover wax removal by an audiologist.
        ii. Should I agree to have wax removed from my ears, I will be charged $40.00 per ear.
    b. Out-of-Warranty Hearing Aid Services
        i. Clean-and-Check
            1. $15.00 for one hearing aid
            2. $25.00 for two hearing aids
        ii. Receiver/Speaker Replacement
            1. $125.00 each
        iii. Repairs
            1. Devices less than five years old
                a. $275.00 per hearing aid
            2. Devices more than five years old
                a. $375.00 per hearing aid
            3. Custom device repair (in-house)
                a. $125.00 per hearing aid
8. I authorize Swank Family Hearing to release my medical records to any referring physician, insurance company, health care facility or government agency requesting such information.
    a. I also authorize the release of my medical information to the following people:

        i. Name: _____ Relationship: _____

        ii. Name: _____ Relationship: _____

By signing below, I have read and agree to the above information.

_____ _____

Patient Signature Date

Advanced Beneficiary Notice (ABN)
Of Patient Responsibility

Please read and sign this ABN so you can make an informed decision about your hearing health care.

Wax Removal

- Most insurance companies do not cover wax removal by an audiologist. Should I decide to have wax removed by an audiologist at Swank Family Hearing, I agree to pay $40.00 per ear for that service.

Hearing Aids

- I understand Swank Family Hearing does its best to obtain accurate information regarding my hearing aid benefits from my insurance company. This information will be used to provide an estimate regarding the out-of-pocket cost of hearing aid technology and services.
- I understand all hearing aid pricing given at the appointment is an estimate, and the final out-of-pocket cost will be determined by my insurance company. I agree that I am responsible for any unmet deductibles set forth by my insurance. I also understand I will be billed any money more than what my insurance plan covers (detailed in your Explanation of Benefits), and I agree to pay all remaining charges.

_____ _____

Patient Signature Date