

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:

- | | | |
|--|-------------------------------------|---|
| <input type="checkbox"/> Behind the Ear | <input type="checkbox"/> Oticon | <input type="checkbox"/> Disposable Batteries |
| <input type="checkbox"/> Custom/In the Ear | <input type="checkbox"/> Phonak | <input type="checkbox"/> Rechargeable Batteries |
| <input type="checkbox"/> Custom Earmold | <input type="checkbox"/> Resound | |
| <input type="checkbox"/> BAHA | <input type="checkbox"/> Signia | |
| <input type="checkbox"/> Cochlear Implant | <input type="checkbox"/> Starkey | |
| <input type="checkbox"/> Other | <input type="checkbox"/> TruHearing | |

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Sounds Are Too Soft | <input type="checkbox"/> Feedback or Whistling | <input type="checkbox"/> Unnatural Sound |
| <input type="checkbox"/> Sounds Are Too Loud | <input type="checkbox"/> Poor Battery Life | <input type="checkbox"/> Do Not Like Appearance |
| <input type="checkbox"/> Poor Fit | <input type="checkbox"/> Pain/Discomfort | <input type="checkbox"/> Frequent Repairs |
| <input type="checkbox"/> Other _____ | | |

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. \$20.00 for one hearing aid
 2. \$40.00 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