COWETA HEARING & BALANCE CLINIC

FAYETTE HEARING CLINIC

WELCOME TO FAYETTE HEARING

PATIENT INFORMATION

Mr. _____ Mrs. _____ Ms. _____ Miss. _____ Dr. _____

FIRST NAME: _____ LAST NAME: _____

PREFERRED NAME: _____ CELL NUMBER: (____) _____- _____

DATE OF BIRTH: _____ HOME NUMBER: (____) _____- _____

AGE: _____ WORK NUMBER: (____) _____- _____

GENDER: _____ SS NUMBER: _____

Email: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE: _____

OCCUPATION: _____

EMPLOYER: _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

EMERGENCY CONTACT PHONE NUMBER: (____) _____-_____ _____

PHYSICIAN INFORMATION

PRIMARY CARE PHYSICIAN: _____

PRIMARY CARE ADDRESS/LOCATION: _____

REFERRING PHYSICIAN: _____

REFERRING PHYSICIAN ADDRESS/LOCATION: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ ID #: _____

GROUP NUMBER: _____ CO-PAY: _____

POLICY HOLDER: _____ DOB: _____

RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE: _____ ID #: _____

GROUP NUMBER: _____ CO-PAY: _____

POLICY HOLDER: _____ DOB: _____

RELATIONSHIP TO PATIENT: _____

By signing below, I agree to be held responsible for all payments due, including any payments due after insurance has been applied. I also Authorize Fayette Hearing Clinic to file insurance on my behalf for services rendered.

_____

PATIENT (Guardian) SIGNATURE **DATE**

Coweta Location:
2301 Newnan Xing Blvd., Ste 160, Newnan, GA 30265
phone 770-254-2224 / fax 770-254-2225

Fayette Location:
8 Eastbrook Bend, Suite A, Peachtree City, GA 30269
phone 770-631-4490 / fax 770-631-4495

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HOW DID YOU HEAR ABOUT US?

PHYSICIAN	ONLINE	INSURANCE CO.
RELATIVE	SOCIAL MEDIA	BUZZN MAGAZINE
FRIEND	CVS	HOMETOWN DIRECTORY
LETTER	MAILER	NEWSPAPER AD
SAW SIGN	RADIO	RESTAURANT
CHAMBER	ROTARY	NATIONAL HEARING CAMPAIGN
YELLOW PAGES	HEALTH FAIR	OTHER

If Physician, Friend Or Relative, Please List Their Name.

_____

If Other, Insurance Company, Internet, or Restaurant, Please Explain.

_____

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We ARE EXCITED TO ANNOUNCE that we recently became

THE ONLY American Institute of Balance (AIB) Center of Specialty Care in the state of Georgia.

This means that we.....

- perform more advanced and complete testing than any other providers.
- have the most advanced and comprehensive equipment available to test vestibular and balance disorders.
- will get to the bottom of your **dizziness or balance** problems!!!

DIZZINESS, FEAR OF FALLING, FALLS, and IMBALANCE IS NOT SOMETHING THAT YOU HAVE TO LIVE WITH!!!

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, PLEASE DISCUSS TESTING WITH YOUR AUDIOLOGIST. WE ARE CURRENTLY SCHEDULING FOR OCTOBER!

1) Do you ever have a feeling of motion, spinning, or falling with sudden head or body movements? (i.e. getting out of bed) YES NO

2) Do you have a fear of falling or stumbling? YES NO

3) Do you have a feeling of unsteadiness or often feel that you are not Sure-footed? YES NO

4) Do you have difficulty maintaining your balance when you are walking on an uneven surface or changing from one surface type to another (i.e. tile to carpet)? YES NO

5) Do you frequently feel like you are pulling or drifting to one side? YES NO

6) Have you fallen in the past year? YES NO

7) Are you uncomfortable trying to get around in the dark? YES NO

8) Do you ever feel that your feet just won't move the way that you want them to? YES NO

9) Do you ever walk like you are intoxicated even though you are not? YES NO

** All of our testing is performed in our Newnan location, 2301 Newnan Crossing Blvd, Suite 160, Newnan, GA 30265 **

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HEARING HANDICAP INVENTORY

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Check **YES, SOMETIMES, or NO** for each Question.

DO NOT SKIP a question! **We will Score the Test.**

QUESTIONS	YES	SOME-TIMES	NO	OFFICE
S-15 Does a hearing problem cause you difficulty when listening to TV or Radio?				S
S-16 Does a hearing problem cause you to go shopping less often than you would like?				S
E-17 Does any problem or difficulty with your hearing upset you at all?				E
E-18 Does a hearing problem cause you to want to be by yourself?				E
S-19 Does a hearing problem cause you to talk to family members less often than you would like?				S
E-20 Do you feel that any difficulty with your hearing limits or hampers your personal or social Life?				E
S-21 Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?				S
E-22 Does a hearing problem casue you to feel depressed?				E
S-23 Does a hearing problem cause you to listen to TV or the radio less often than you would like?				S
E-24 Does a hearing problem casue you to feel uncomfortable when talking to friends?				E
E-25 Does a hearing problem cause you to feel left out when you are with a group of people?				E
Do both of your ears hear the same?		YES	NO	
Do you have ringing / buzzing in your ears?		YES	NO	

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MEDICATION LOG

(prescribed, supplements and OTC meds)

Patient Name: _____ **Date:** _____

*** IF YOU HAVE MEDICATION LIST WE CAN MAKE A PHOTO COPY

MEDICATION NAME	REASON FOR TAKING	DOSE GIVEN	FREQUENCY (i.e. 2x per Day	TIME AM or PM	WHEN PRESCRIBED

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HIPAA COMPLIANCE

HIPAA (Health Insurance Portability Act of 1996) is a regulation designed to protect confidential healthcare information through improved security standards and federal privacy legislation. it defines requirements for storing patient information before, during and after electronic transmission. It also identifies compliance guidelines for critical business tasks such as risk analysis, awareness training, audit trail, disaster recovery plans and information access control and encryption.

The HIPAA regulation has three main components that apply to "covered entities" (a covered entity is any provider of healthcare services that charges the government or insurance for their services):

1. Standard Transaction Code Sets
2. Patient Information Privacy
3. Patient Information Security (both electronic and physical records)

We are HIPPA compliant.

1. We will not disclose to anyone known or not known to you the reason you came to our office, the outcomes of testing, recommendations, nor any discussions that were made between you and our personnel without your written consent.
2. We will not provide personal information about you to any outside source. Your information including address, phone number, social security number, etc. will only be used by us to contact you or to file necessary insurance claims.
3. In addition to secured files, we use a database system that has been tested and has proven the highest levels of security which, in some cases surpass the government regulations for security.

Patient (Guardian) Signature_____ Date_____

Consent for Treatment, Privacy and Release

I consent to receive audiological services from Fayette Hearing and Clinic. This consent encompassed audiological procedures including, but not limited to: diagnostic testing, rehabilitative treatment, ear wax removal, touching of ears and head and taking of ear mold impressions. I understand that this consent form will be valid and remain in effect as long as I receive audiological care from Fayette Hearing Clinic.

Patient (Guardian) Signature_____ Date_____

In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical records may be released to my physician, a designated referral physician and/or the provider, if any, who referred me here.

Patient (Guardian) Signature_____ Date_____

I hereby authorize the release of any medical or other information necessary to process my insurance claim. I further authorize payment of medical benefits to Fayette Hearing Clinic for the services described on the insurance form. This authorization is to apply to all occasions of services until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office. This is to serve as a long-term authorization.

May we at Fayette Hearing Clinic contact you via phone, e-mail, or regular mail to inform you of your appointments, specials, and/or reminders?

_____ YES _____ NO

Please List anyone you wish for us to be able to speak with regarding your medical records.

Name: _____ Relationship: _____ Phone #: _____

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If your hearing test indicates that hearing aids are recommended, our Audiologists can discuss hearing aid options and recommendations for a consultation fee of $45. Please note that insurance does not cover this fee.

_____

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