Dr. Nikki DeGeorge Weaver, Audiologist

Welcome to Coweta Hearing Clinic

PATIENT INFORMATION

Mr. _____ Mrs. _____ Ms. _____ Miss _____ Dr. _____ Age _____
First Name _____ Last Name _____ M.I. ___
Date of Birth ___/___/___ Gender _____ Phone Number (____) _____ - _____
SS Number ____ _____ _____ Phone Number (____) _____ - _____

Street Address _____
City _____ State _____ Zip Code _____
E-Mail Address _____

Occupation / School_____
Employer / Parent's Employer_____

Spouse's / Parents Name _____

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 # _____ Co-Pay _____
Policy Holder _____ Relationship to Patient _____

Secondary Insurance _____ ID# _____
Group # _____ Co-Pay _____
Policy Holder _____ Relationship to Patient _____

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

_____
Patient (Guardian) Signature Date

HEARING DIFFICULTY QUESTIONNAIRE

Name: _____ **Date Completed:** _____

For each situation listed below, indicate how much difficulty you have hearing , as well as how important hearing well in that situation is to you.

LISTENING SITUATION	HEARING QUALITY					IMPORTANCE TO YOU		
	POOR				NORMAL	NOT	SOMEWHAT	VERY
QUIET (one on one conversation)	1	2	3 ◉	4	5	○	○	○
TELEVISION	1	2 ◉	3	4	5	○	○	○
LEISURE ACTIVITIES (list)*	1	2 ◉	3	4	5	○	○	○
RESTAURANTS	1	2	3 ◉	4	5	○	○	○
CHURCH	1 ◉	2	3	4	5	○	○	○
MEETINGS/GROUPS	1	2	3	4 ◉	5	○	○	○
WORK PLACE	1	2	3 ◉	4	5	○	○	○
TELEPHONE	1	2	3 ◉	4	5	○	○	○
CAR	1	2 ◉	3	4	5	○	○	○
MALE VOICE	1	2	3	4	5	○	○	○
FEMALE VOICE	1	2	3	4	5	○	○	○
CHILD'S VOICE	1	2	3	4	5	○	○	○
OTHER (please specify)	1	2	3	4	5	○	○	○
*	1	2	3	4	5	○	○	○
**	1	2	3	4	5	○	○	○

NAL Client Oriented Scale of Improvement (COSI)

The COSI is a tool to assist the dispenser in measuring the success of your new hearing aid fitting. Please list 5 improvements you hope to realize with your new hearing aids. Please be as specific as possible ("understanding my grandchildren sitting in the back of the minivan" instead of "hearing children's voices better").

Dispenser: _____

Dates: 1. Needs established _____

2. Outcome measured _____

SPECIFIC NEEDS (Indicate Order of Significance)		Degree of Change "With the hearing aid , I hear..."					Final Ability (with hearing aid) "I can hear satisfactorily..."				
		Worse	No Difference	Slightly Better	Better	Much Better	Hardly Ever 10 %	Occasionally 25 %	Half the Time 50 %	Most of theTtime 75 %	Almost Always 95 %
		1	2	3	4	5	1	2	3	4	5
	1	○	○	○	○	○	○	○	○	○	○
	1	○	○	○	○	○	○	○	○	○	○
	1	○	○	○	○	○	○	○	○	○	○
	5	○	○	○	○	○	○	○	○	○	○
	5	○	○	○	○	○	○	○	○	○	○

HI Form – Patient

Name: _____ Date: _____

Check ***Unaided*** if you do not wear hearing aids, or ***Aided*** if you wear a hearing aid. Your responses to the questions should relate to your perceptions of your hearing under the specific condition indicated.

◉ Unaided ○ Aided

Select ***No, Sometimes,*** or ***Yes*** in response to each question. If you do not engage in a particular activity, respond according to the way you feel you would respond in that situation.

1. Does a hearing problem cause you to feel embarrassed when you meet new people?
☐ NO ☐ SOMETIMES ☐ YES

2. Does a hearing problem cause you to feel frustrated when talking to members of your family?
☐ NO ☐ SOMETIMES ☐ YES

3. Do you have difficulty hearing or understanding co-workers, clients, or customers?
☐ NO ☐ SOMETIMES ☐ YES

4. Do you feel handicapped by a hearing problem?
☐ NO ☐ SOMETIMES ☐ YES

5. Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?
☐ NO ☐ SOMETIMES ☐ YES

6. Does a hearing problem cause you difficulty in the movies or in the theater?
☐ NO ☐ SOMETIMES ☐ YES

7. Does a hearing problem cause you to have arguments with family members:
☐ NO ☐ SOMETIMES ☐ YES

8. Does a hearing problem cause you difficulty when listening to TV or radio?
☐ NO ☐ SOMETIMES ☐ YES

9. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?

☐ NO ☐ SOMETIMES ☐ YES

10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?
☐ NO ☐ SOMETIMES ☐ YES

11. What problems do you experience because of hearing loss? _____
_____

12. What steps can you take to improve communications? _____
_____

13. Where do you communicate well? _____
_____

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 HIPAA compliant.

1. We will not disclose to anyone known or not know 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 Coweta Hearing Clinic. This consent encompasses 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 Coweta 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 Coweta Hearing Clinic for the services described on the insurance form. This authorization is to apply to all occasions of service 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 Coweta 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_____ Relation_____ Phone#_____

How did you hear about us? (Please circle **all** that apply.)

98.1 FM	Mailer	Physician
720 AM	Letter	Friend
1470 AM	Newspaper Ad	Relative
Buzzn Magazine	National Hearing Campaign	Insurance Co.
Bellsouth Yellow Pages	Yellow Book	Internet
Hometown Directory	Saw Sign	Chamber
Rotary	Restaurant	Other

If Physician, Friend or Relative, please list their name.

_____

If Other, Insurance Company, Internet, or Restaurant, please explain.

_____