

Coweta Hearing Clinic
2301 Newnan Crossing Blvd., Suite 160
Newnan, GA 30265

Fayette Hearing Clinic
8 Eastbrook Bend, Suite A
Peachtree City, GA 30269

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

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 check **all** that apply.)

- | | | |
|---|--|--|
| <input type="checkbox"/> 98.1 FM | <input type="checkbox"/> Mailer | <input type="checkbox"/> Physician |
| <input type="checkbox"/> 720 AM | <input type="checkbox"/> Letter | <input type="checkbox"/> Friend |
| <input type="checkbox"/> 1470 AM | <input type="checkbox"/> Newspaper Ad | <input type="checkbox"/> Relative |
| <input type="checkbox"/> Buzzn Magazine | <input type="checkbox"/> National Hearing Campaign | <input type="checkbox"/> Insurance Co. |
| <input type="checkbox"/> Bellsouth Yellow Pages | <input type="checkbox"/> Yellow Book | <input type="checkbox"/> Internet |
| <input type="checkbox"/> Hometown Directory | <input type="checkbox"/> Saw Sign | <input type="checkbox"/> Chamber |
| <input type="checkbox"/> Rotary | <input type="checkbox"/> Restaurant | <input type="checkbox"/> Other |

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

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