Hearing Associates of Northern Virginia

PLEASE PRINT CLEARLY

Last Name:_____First Name:_____MI:_____Email Address:_____

Address: _____Apt. #_____City _____State_____ ZIP_____

Home Phone: (____)_____Cell Phone: (____)_____Work Phone: (____)_____

Date of Birth:_____ Age:_____ Gender:____ Marital Status:___ Spouses Name:_____

Occupation:_____ (If Retired) Former Occupation:_____

Whom may we contact in case of emergency? _____Phone: (____)_____

Primary Insurance: _____Policy#_____Grp#_____

Secondary Insurance: _____Policy#_____Grp#_____

Whom may we thank for referring you to us? _____

How may we help you today? _____

Financial Responsibility Statement- PLEASE READ CAREFULLY

Your visit today will include a hearing evaluation. The Hearing Associates of Northern Virginia may or may not participate with your insurance company. Please verify your insurance coverage for any hearing evaluation or procedures recommended prior to any testing if you are concerned as to the extent of your coverage. The Hearing Associates of Northern Virginia staff will advise you to the best of our knowledge on your benefits if possible, but as coverage and plans are constantly changing we cannot be responsible for knowing what your particular insurance covers as a benefit.
By agreeing to the recommended evaluation(s) you are also acknowledging that you either have verified your benefits with your insurance company or choose not to do so prior to testing. Any portion of the testing not paid by your insurance company is your sole responsibility. The Hearing Associates of Northern Virginia will do the billing for you, but is not responsible for securing payment by your insurance company.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize release of any medical information necessary in the course of treatment.
Please sign below to acknowledge that you have read and understood the above information.

Patient's Signature:_____ Date: _____

Signature of Guardian:_____ Date: _____

Hearing Associates of Northern Virginia

Name: _____ Date: _____

Have you had your hearing tested before? _____ YES _____ NO

If yes – Where was your hearing tested? _____When?_____

Was a hearing loss noted at that time? _____ YES _____ NO

Recommendations? _____

Is there a history of hearing loss in your family? _____ YES _____ NO

Do you or have you ever worked in a noisy place? _____ YES _____ NO

List any medications you are currently taking: _____

Have you seen an Ear, Nose and Throat Physician? _____ YES _____ NO

If yes – Who did you see? _____ When? _____Why?_____

CHECK IF ANY OF THE FOLLOWING APPLIES TO YOU:

___ Active drainage from either ear within the past 90 days

___ Sudden or rapid progressive hearing loss within the past 90 days

___ Head noise (ringing, buzzing, roaring)

___ Sudden or recent onset of hearing loss in one ear within the past 90 days

___ Deformity of either ear

___ Acute or chronic dizziness

___ Pain/discomfort in either ear

HEARING HISTORY - CHECK IF ANY OF THE FOLLOWING APPLIES TO YOU

___ I ask others to repeat what they have said

___ I hear but I don't always understand the words

___Others complain that my television is too loud

___ Others complain that I don't hear

___People seem to mumble

___Others say that I speak too loudly

HEARING AID USER

Which ear is aided? ___ Right Ear ___ Left Ear ___ Both

Date of purchase: _____ Place of purchase: _____

WHILE WEARING YOUR HEARING AID(S) DO YOU HAVE ANY OF THESE PROBLEMS?

___Difficulty understanding speech

___Difficulty distinguishing sound direction

___Difficulty understanding on the phone

___ Difficulty understanding in groups, restaurants, or in noisy situations

___Ears are sore

___Sounds aren't loud enough

___My hearing aid(s) whistle

HEARING ASSOCIATES OF NORTHERN VIRGINIA
6862 Elm St. #120 McLean, VA 22101

Patient Acknowledgement and Consent Form

Acknowledgement of Notification

The educational material entitled "Notice of Privacy Practices" provides information about how the Hearing Associates of Northern Virginia may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, we will post the change in our office.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, or health care operations. We are not required to agree to your restrictions: but if we do we are bound by our agreement with you.

We believe that your health information is private to you. We make every effort to protect your information from unnecessary disclosure, including the following procedures; We educate our staff to keep information confidential; we discard protected information in appropriate containers or shred it; we require your written authorization prior to disclosing information to sources not identified in our privacy practices; you may revoke your written authorization at any time by sending us a written request.

By signing below, you acknowledge that our Privacy Policy has been available to you.

_____

Patient's Signature Today's Day

Consent for us and Disclosure of Information

By signing below, you consent to the use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare or any other insurance carrier benefits be made on my behalf to the Hearing Associates or Northern Virginia for any services and/or products furnished to me by the health care specialist or supplier. I authorize any holder of medical information about me to release to the Centers of Medicare Services and its agent and/or any other insurance carriers for which I have coverage, any information needed to provide all referral as required by my insurance carriers. All co-pays must be paid at time of services in accordance with the contracted insurance carrier agreements. All non-covered services and/or products must be paid for all the time the service is rendered or the product is dispensed.

_____

Patient Signature Today's Date