Patient Information: This section refers to the PATIENT only.

Name:_____ Address:_____

City: _____ State:_____ Zip Code _____

Home Phone: _____ Cell Phone:_____ Occupation:_____

DOB: _____ Sex: _____ Email:_____

Please complete if the person responsible for billing is someone other than the patient.

Name:_____ Relationship to Patient: _____

PLEASE GIVE ALL INSURANCE CARDS TO SECRETARY

Primary Care Physician: _____

Would you like a copy of your audiogram (hearing test) sent to your PCP? _____

Whom may we thank for referring you to us? _____

PLEASE SIGN: Patient's signature for the release of medical information: I authorize the release of information necessary to file a claim with my insurance carrier and request payment of benefits to the audiologist if fees have not been pre-paid. I understand that I am financially responsible for any balance not covered by my insurance.

Signature: _____ Date: _____

PLEASE SIGN: I authorize the release of any payments and medical information necessary to process/pay claims for services furnished to me by Audiology Associates of Worcester. I request payment of authorized Medicare benefits be made on my behalf to Audiology Associates of Worcester. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

Signature: _____ Date: _____

AUDIOLOGY ASSOCIATES of Worcester

Hearing Questionnaire

1. What motivated you to come in today?

_____

2. On a scale of 1-10, how motivated are you to do something about your hearing loss? (Please circle one):

Not motivated 1 2 3 4 5 6 7 8 9 10 Very Motivated

3. What is your hearing aid experience? Please answer the following:

Have you ever worn a hearing aid? Please circle: YES/NO
Do you use a hearing aid now? Please circle: YES/NO

If YES, how long have you had a hearing aid? _____

On which ear do you use the hearing aid(s)? Please circle: RIGHT/LEFT

Do you have any complaints about your current devices?_____

4. Please rank the following items on a scale of 1 to 4 in terms of importance when purchasing a hearing device. Please use each number only *once*.
(1 = Most Important 2 = Important 3 = Somewhat Important 4 = Least Important)

☐ Sound Quality/Clarity ☐ Durability/Reliability ☐ Cost ☐ Appearance

5. In which of the following situations do you have difficulty hearing? Please check all that apply:

Listening Situation	Difficulty? Check all that apply
Television	☐
Music	☐
Restaurants	☐
Church	☐
Meetings/Lectures	☐
Work Place	☐
Telephone	☐
Large Social Gathering	☐
Quiet Room (1-2 People	☐

HIPAA

Authorization for the Use or Disclosure of Protected Health Information

I consent to the use or disclosure of my protected health information (including audiograms) by Audiology Associates of Worcester, Inc. for the purpose of diagnosing or providing hearing care and treatment to me.

I understand that diagnosis or treatment of me by Audiology Associates may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out hearing care and treatment. Audiology Associates is not required to agree to the restrictions that I may request. However, if Audiology Associates agrees to a restriction that I request, the restriction is binding on Audiology Associates.

I have the right to revoke this consent, in writing, at any time, except to the extent that Audiology Associates has taken action in reliance on this consent.

My "protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to Audiology Associates use or disclosure of my PHI for purposes of delivering relevant product and/or technology marketing communication to me. I acknowledge that Audiology Associates may receive financial remuneration from the manufacturer in connection with such communications.

_____

Patient Name

_____

Signature

_____

Personal Representative other than Patient

_____

Date