ELEVATE AUDIOLOGY
Hearing & Tinnitus Center

DEMOGRAPHICS

Name: _____ Today's Date: _____

Birthdate: _____ Age: _____

Referring/Primary Care Physician(s): _____

Marital Status: ___ Single ___ Married ___ Widowed ___ Divorced ___ Other

___ Mr. ___ Mrs. ___ Ms. ___ Miss ___ Dr.

What is your primary reason for coming in today?_____

Who can we thank for sending you to our office today? _____

HEARING HISTORY

Have you ever had a hearing evaluation before? ___ Yes ___ No

If you suspect a hearing loss, do you feel the onset was: ___ Gradual ___ Sudden ___ Fluctuating

Have you been around loud sounds regularly? ___ Yes ___ No

Do you have trouble hearing any of the following?

___ Doorbell ___ Telephone Ring ___ Alarm Clock ___ Sirens

___ Baby Cry ___ Fire/Smoke Detector ___ Birds Singing ___ Car Blinker

Have you ever worn a hearing aid? ___ Yes ___ No

Do you use a hearing aid now? ___ Yes ___ No

MEDICAL HISTORY

Have you had earaches or drainage from your ears in the past 90 days? ___ Yes ___ No

Have you ever had medical/surgical treatment for your ears? ___ Yes ___ No

Do you ever experience balance issues, dizziness, lightheadedness, or falls? ___ Yes ___ No

Have you ever had a head injury? ___ Yes ___ No

Do you experience tinnitus regularly? (i.e. ringing, buzzing, humming, roaring) ___ Yes ___ No

Does anyone in you immediate, biological family have hearing loss? ___ Yes ___ No

Are you taking blood thinners? ___ Yes ___ No

Have you been diagnosed with any of the following?

___ Arthritis
___ Bell's Palsy
___ Cancer
___ Chronic Kidney Disease
___ Concussion/Skull Fracture
___ Dementia or Alzheimer's
___ Depression or Anxiety
___ Diabetes □ Type I □ Type II
___ Heart Disease
___ Hepatitis
___ Blood Pressure □ High □ Low
___ High Fevers
___ HIV/AIDS
___ Measles
___ Meningitis
___ Multiple Sclerosis
___ Pacemaker
___ Parkinson's
___ Scarlet Fever
___ Seizures
___ Stroke/TIA
___ Tuberculosis
___ Vision Issues

___ Other, please explain _____

Are you allergic to latex, acrylic, silicone, etc? ___ Yes (which?)_____ ___ No

Is there any other important information related to your hearing that the doctor should know?

_____

_____

Hearing Handicap Inventory (HHIE-S)

Instructions: Please check “yes,” “no,” or “sometimes” in response to each of the following items. Do not skip a question if you avoid a situation because of a hearing problem. If you use a hearing aid, please answer the way you hear *without* the aid.

	Item	**Yes**	**Sometimes**	**No**
E	Does a hearing problem cause you to feel embarrassed when meeting new people?			
E	Does a hearing problem cause you to feel frustrated when talking to members of your family?			
S	Do you have difficulty hearing when someone speaks in a whisper?			
E	Do you feel handicapped by a hearing problem?			
S	Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?			
S	Does a hearing problem cause you to attend religious services less often than you would like?			
E	Does a hearing problem cause you to have arguments with family members?			
S	Does a hearing problem cause you difficulty when listening to TV or radio?			
E	Do you feel that any difficulty with your hearing limits or hampers your personal or social life?			
S	Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?			

Hearing Inventory for Companion

Name: _____ Date: _____ HI Score:_____

Patient: _____ Relationship to Patient: _____

At Elevate Audiology, it is our mission to find the best personal solution for each person's communication needs. We will only be successful in reaching this goal if we take the time to compile the following information from those closest to you. Communication is a two-way street!

	Yes	Sometimes	No
Have you observed a situation where a hearing problem caused him/her to feel embarrassed when meeting new people?			
Do you feel a hearing problem causes him/her to feel frustrated when talking to members of his/her family?			
Have you noticed that he/she has difficulty hearing when someone speaks in a whisper?			
Do you believe he/she is burdened by a hearing problem?			
Are you concerned that a hearing problem causes him/her difficulty when visiting friends, relatives, or neighbors?			
Do you think that a hearing problem cause him/her to attend large group situations less often than they would like?			
Have you noticed that a hearing problem cause him/her to have arguments with family members?			
Have you noticed that a hearing problem cause him/her difficulty when listening to TV or radio?			
Are you concerned that any difficulty with his/her hearing limits or hampers their personal or social life?			
Have you observed that a hearing problem causes him/her difficulty when in a restaurant with relatives or friends?			

Is there any other important information related to the patient's hearing or communication that the doctor should know?

_____

_____

_____

Assignment of Insurance Benefits/Release of Information

____ Insurance coverage is an agreement between you and your insurance carrier. I hereby assign all insurance benefits to which I am entitled, including Medicare, private insurance, and any other health plans to Elevate Audiology. The assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance, based on my individual insurance benefits/contracts. I hereby authorize said assignee to release all information that is necessary to secure payment.

Permission for Treatment

____ I hereby voluntarily consent to audiological care and audiological diagnostics by Elevate Audiology, deemed advisable and necessary in the diagnosis and treatment of my hearing condition. I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

Receipt of Notice of Privacy Policy

____ I have received a copy of Elevate Audiology's Privacy Policies and understand its contents. I further acknowledge that a copy of the current notice will be posted in the reception area, website, and any changes will be made available to me.

Please check all boxes then sign below

_____ _____

Signature Date

Disclosure of Patient Authorization Record

I authorize that my personal information, hearing healthcare treatment, and financial information may be assessed by and disclosed to the individuals listed (i.e. spouse, family member, caregiver, friend, etc.).

Name	Relation	Telephone #
_____	_____	_____
_____	_____	_____
_____	_____	_____

Confidential Communication

I authorize communications by Elevate Audiology concerning scheduled appointments, treatment, practice information, newsletters, etc. through the following methods:

Please select all that apply: ___ Phone ___ Text ___ Email ___ Work

Home:	(_____) _____-_____	Authorize messages?	___ Yes	___ No
Cell:	(_____) _____-_____	Authorize messages?	___ Yes	___ No
Work:	(_____) _____-_____	Authorize messages?	___ Yes	___ No

Email: _____

Preferred method for appointment reminders? ___ Phone ___ Text ___ Email ___ Work

Elevate Audiology
Office & Financial Policy

Welcome to our office
Please read this policy carefully and feel free to ask questions regarding any part of the form. Our goal is to provide you excellent hearing care in a comfortable, personal, and cost-effective manner. We hope that you will recognize that our financial policies have been developed to maintain this health care service for our patients and for the community, which means lower fees for you. You can help by paying for your care in a timely manner.

Payment at the time of service is expected.
Payment for services is due in full at the time of service. Payments to Elevate Audiology may be made by cash, check, Visa, MasterCard, or approved financing companies.
In order to bill your insurance company for your hearing care, it is extremely important that we obtain complete and accurate information about your primary and supplement insurance coverage, including phone numbers, addresses, and a copy of your cards. Even though we bill your insurance company for you, we will still collect any office copayments from you at the time of service.

Verification of Benefits
We may assist you, at our discretion, in verifying your insurance coverage in an effort to verify exactly what audiology coverage is available within your policy. This can only be done on the day of your appointment if time permits. **You as the policy holder are primarily responsible to verify benefits.** We cannot guarantee payment of the benefits and subsequently you may be responsible for any coinsurance, deductibles, or fees for non-covered services that may result. Insurance coverage is an agreement between you and your insurance carrier.

Referrals
If your insurance company requires a referral and/or preauthorization/precertification **you are** responsible for obtaining it. We most likely will not be able to obtain a referral on the date of service. (This will be our discretion if time permits). An option at this point will be to reschedule the appointment or to pay at the time of service. We suggest you call your primary care doctor at least 24 hours in advance to confirm that your referral has been generated and faxed. **The most reliable method is to obtain it yourself.**

Medicare
We accept assignment from Medicare so all payment from Medicare will be made directly to the doctor. We bill Medicare and your supplemental insurance directly. We are required by Federal Law to collect the amount Medicare approves, not just the 20% they do not pay.

No Show and Cancellation Appointments/Late Arrivals
We will reach out to you at least the day before your appointment to confirm your attendance. If we do not reach you, we will leave a message via voicemail or email (if able). Please give at least 24 hours notice if unable to keep an appointment. We reserve the right to charge a $25 fee for missed appointments or appointment cancelled without 24 hour notice. We understand late arrivals happen. Unfortunately, we have patients scheduled throughout the day and may not be able to see you if you arrive more than 15 minutes after your scheduled appointment time. We will try to accommodate you if time allows, otherwise, we will need to reschedule.

Returned Checks
There is a fee (currently $25) for any checks returned by the bank.

Monthly Statement
If you have a balance on your account we will send you a monthly statement. It will show the balance and any new charges to the account. Any unpaid balances older than 30 days may be subject to 1.5% interest fee per month.

Payments
Unless other arrangements are approved by us in writing, the balance on your account is due and paid when the statement is issue. If not paid by the end of the month it will be considered past due.

Past Due Accounts
If your account becomes past due, we will take the necessary steps to collect this debt. This may mean a collections agency. In the event of legal action, you will be responsible for payment of any additional charges equal to the cost of collections, including agency fees, attorney fees, and court costs incurred, as permitted by law governing this transaction.

Effective Date
Once you have signed this document, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Financial Agreement
-I agree to pay promptly all fees and charges for treatments provided to me and/or my family.
-I have read the policies above and understand them.
-I understand that I am financially responsible for all charges, whether or not they are covered by my insurance.
-I authorize Elevate Audiology to release to my insurance carrier any medical information needed to obtain payment for services.
-I understand that if I disagree with any charges, I will contact this office in writing within 30 days of the billing date.

We will work with you to ensure your hearing care is the finest available and it does not become a financial burden.

Signature: _____ Date: _____