ELEVATE AUDIOLOGY
Hearing & Tinnitus Center

HEARING CASE HISTORY

DEMOGRAPHICS

Name: _____ Today's Date: _____

Birthdate: _____ Age: _____

Referring/Primary Care Physician(s): _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other

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 exposed to very loud sounds? ☐ Yes ☐ No

If yes, ☐ Military ☐ Recreational ☐ Employment ☐ Music

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

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

Check if you have trouble hearing any of the following: ☐ Doorbell ☐ Telephone Ring ☐ Alarm Clock ☐ Smoke Alarm

MEDICAL HISTORY

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

Have you ever had medical or surgical treatment for your ears? ☐ Yes ☐ No

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

Have you ever had a significant head injury? ☐ Yes ☐ No

Do you have a known genetic family history of hearing loss or ear problems? ☐ Yes ☐ No

Are you taking blood thinners? ☐ Yes ☐ No

Do you smoke anything, or are you exposed to secondhand smoke? ☐ Smoker ☐ No ☐ Secondhand

Do you or your family have concerns about your memory or brain health? ☐ Yes ☐ No

Have you ever been diagnosed with any of the following?

☐ Anxiety	☐ Autoimmune Disorder	☐ Bell's Palsy	Blood Pressure ☐ High ☐ Low	☐ Cancer ☐ Chemo ☐ Radiation	☐ Chronic Kidney Disease	☐ Concussion/ Skull Fracture	☐ Dementia or Alzheimer's
☐ Depression	Diabetes ☐ Type I ☐ Type II	☐ Heart Disease	☐ Hepatitis	☐ High Fevers	☐ HIV/AIDS	☐ Latex, Acrylic or Silicone Allergy	☐ Measles
☐ Meningitis	☐ Mild Cognitive Impairment	☐ Multiple Sclerosis	☐ Mumps	☐ Neurological Disorders	☐ Pacemaker	☐ Parkinson's	☐ Scarlet Fever
☐ Seizures	☐ Sinus or Allergy Issues	☐ Stroke/TIA	☐ Thyroid Issues	☐ Tuberculosis	☐ Vision Issues		
☐ Other, please explain: _____							

Is there any other relevant information that the doctor should know?

• 838 Powdersville Rd. Suite L, Easley, SC 29642 •

• 864.442.5555 •

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REVISED HEARING HANDICAP INVENTORY - SCREENING (RHHI-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.

		YES	SOMETIMES	NO
S	Does a hearing problem cause you difficulty when listening to the TV or radio?	☐	☐	☐
S	Does a hearing problem cause you difficulty when attending a party?	☐	☐	☐
E	Does a hearing problem cause you to feel frustrated when talking to members of your family?	☐	☐	☐
E	Does a hearing problem cause you to feel left out when you are with a group of people?	☐	☐	☐
S	Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?	☐	☐	☐
E	Do you feel handicapped by a hearing problem?	☐	☐	☐
E	Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	☐	☐	☐
E	Does a hearing problem cause you to feel uncomfortable when talking to friends?	☐	☐	☐
S	Does a hearing problem cause you to avoid groups of people?	☐	☐	☐
S	Does a hearing problem cause you to visit friends, relatives or neighbors less often than you would like?	☐	☐	☐

How important is it for you to hear better? Choose a box on the line.

Not Very Important ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Very Important
0 1 2 3 4 5 6 7 8 9 10

How motivated are you to wear and use hearing aids if recommended? Choose a box on the line.

Will Not Wear ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Will Wear Consistently
0 1 2 3 4 5 6 7 8 9 10

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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 visit friends, relatives or neighbors less often than you would like?	☐	☐	☐
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 appears left out when around a group of people?	☐	☐	☐
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 causes him/her to avoid groups of people?	☐	☐	☐
Have you noticed that a hearing problem causes him/her to be uncomfortable when talking to friends?	☐	☐	☐
Have you noticed that a hearing problem causes 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 attending a party?	☐	☐	☐

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

_____

_____

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CURRENT MEDICATIONS LIST

Name: _____

Date Last Updated: _____ _____ _____ _____

Prescription Medications:

Name of Medication	Dosage	Frequency (i.e., once per day)	Condition Medication Taken For	Physician Who Prescribed Med

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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 insurance benefits/contracts. I hereby authorize said assignee to release all information that is necessary to secure payment. Any required physician orders are the responsibility of the patient to receive prior to the appointment time.

Permission for Treatment

_____ I hereby voluntarily consent to audiological diagnostics, care and services by Elevate Audiology, deemed advisable and necessary in the diagnosis and treatment of my audiology condition. I acknowledge that no cures nor guarantees have been made to me as a result of treatment or examination in the office.

Receipt of Notice of Privacy Policy

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

Education and Marketing

_____ I authorize Elevate Audiology to send me educational and marketing information on the products and services offered by Elevate Audiology. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

Please check all boxes, then sign below.

_____ _____
Signature Date

Disclosure of Patient Authorization Record

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

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

Confidential Communication

I authorize communications by Elevate Audiology concerning scheduled appointments, treatment, practice information, newsletters and marketing 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

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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 important that we obtain complete and accurate information about your primary and supplemental insurance coverage, including phone numbers, addresses and a copy of your cards. We will submit a claim to your insurance as a courtesy to you. If your insurance reimburses us rather than you, we will refund you or apply the amount to your next visit. Out-of-network insurance beneficiaries and noncovered services are the financial responsibility of the patient.

Verification of Benefits

We may assist you, at our discretion, in verifying your insurance coverage in an effort to verify audiology coverage within your policy. Verification is not a guarantee of payment, and you as the policyholder are primarily responsible for verifying benefits. This can only be done on the day of your appointment if time permits. You are responsible for any coinsurance, deductibles or fees for noncovered services that may result. Insurance coverage is an agreement between you and your insurance carrier.

Referrals

If your insurance company requires a referral 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. An option will be to reschedule the appointment or 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.

Medicare

We accept assignments from Medicare, so all payments from Medicare will be made directly to our office for Medicare-covered services only. 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 one 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 appointments canceled without 24 hours' 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 after your scheduled time. We will need to reschedule if we are unable to accommodate due to late arrival.

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 a 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 issued. 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 collection 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 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.

Signature _____ Date _____