Patient Registration Form

Patient Name: _____ Today's Date _____
First *MI* *Last*

Choose One: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Email: _____

Date of Birth: _____/_____/_____ Age: _____
mm *dd* *yyyy*

Address: _____

_____

Primary Phone # _____ Secondary Phone # _____

Preference of Contact: (mark all that apply) ☐ Phone ☐ Email ☐ Text

Permission to communicate via text ☐ Yes ☐ No

Permission to communicate via email ☐ Yes ☐ No
(Medical reports, invoices, confirm appointments)

Permission to communicate via email ☐ Yes ☐ No
(Educational seminars, special events, yearly services)

Primary Care Physician: _____ Phone # _____

Would you like us to send a report to your physician? ☐ Yes ☐ No

How did you hear about Professional Hearing Services?

- ☐ Referred by Physician
- ☐ www.prohearingonline.com
- ☐ Referred by friends or family
- ☐ Other: _____
- ☐ Insurance Referral
- ☐ Google/Internet Search
- ☐ Advertisement/Mailer

Insurance: Please provide the most current **PRIMARY** and **SECONDARY** insurance ID cards to the front desk we can confirm benefits and copies can be made for our records.

HIPPA - Authorization for the Use or Disclosure of Protected Health Information (PHI)

I consent to the use or disclosure of my Protected Health Information (including audiograms) by Professional Hearing Services Inc. (provider) for the purposes of diagnosing or providing hearing care and treatment of me

.

I understand that diagnosis or treatment of me by Provider 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 is used or disclosed to carry out hearing care and treatment. Provider is not required to agree to the restriction I may request. However, if Provider agrees to a restriction that I request, the restriction is binding on Provider.

I have the right to revoke this consent, in writing, at any time, except to the extent that Provider has taken action 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 health care clearing house. 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 Provider's use or disclosure of my PHI for purposes of delivering relevant and/or technology marketing communication to me. I acknowledge that Provider may receive financial remuneration from the manufacturer in connections with such communications.

_____ _____ _____
Signature of Patient or Personal Representative | Print Name of Patient or Personal Representative | Date

Pro Hearing Services
MOBILE AUDIOLOGY

Assignment of Insurance Benefits

Your insurance is a private contract between you and your insurance company. We cannot guarantee payment of your claims or accept responsibility for negotiating claims with you insurance company. As a courtesy, we will be happy to help you determine the coverage you have available. For service not covered we gladly accept cash, check, Visa, MasterCard, and Discover as well as Care Credit financing. Payment arrangements can be made through our office if necessary. Interest will be charged on accounts with balances at 60 days at a rate of 1.5% per month or 18% annually. A $25 service charge will be assessed to your account for any check returned by your bank.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and of health claims to Professional Hearing Services, Inc. A photocopy of my insurance card(s) and my driver's license are to be considered as valid as the original.

I am financially responsible for all charges whether or not paid by the above insurance. I hereby authorize Profession Hearing Services, Inc to release all information necessary to secure payment. If the insurance pays only a portion of the amount due or fails to make payment to Professional Hearing Services, Inc within 90 days, I will be responsible for payment of the balance in full at that time.

_____ _____

Signature of Patient/ Responsible Party Date Signed

Important Notice to Patients

It is impossible for us to know every insurance company plan and contract. Therefore, each patient is responsible for understanding his or her own policy. The insurance contract is between you and the insurance company and not Professional Hearing Services. It is important that you provide us with your current insurance information. Without a copy of your insurance card, we are unable to file a claim. If you do not provide us with the proper insurance information at the time of service, it will be your responsibility to file the claim privately.

_____ _____ _____

Patient or responsible Party – Please Print Signature of Patient/ Responsible Party Date

Pro Hearing Services
MOBILE AUDIOLOGY

Client's Initials _____ **Date** _____

Medical & Audio logical History

WILL THIS BE YOUR FIRST HEARING TEST? YES NO
IF NO, WHEN WAS THE LAST TEST? _____

DO YOU WEAR HEARING AIDS? YES NO
IF SO, WHAT KIND & HOW LONG? _____

HAVE YOU EVER HAD EAR SURGERY? YES NO

DO YOU HAVE ANY OF THE FOLLOWING?

DEFORMITY OF THE EAR? YES NO
EAR DRAINAGE? YES NO

SUDDEN OR RAPID HEARING LOSS IN THE PAST 90 DAYS? YES NO
ACUTE OR RECURRING DIZZINESS? YES NO

EAR PAIN? YES NO

HEARING IN ONE EAR DECREASED IN THE PAST 90 DAYS? YES NO

CHRONIC EAR WAX PROBLEMS? YES NO

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? _____

_____

WHAT BROUGHT THE CURRENT PROBLEM TO YOUR ATTENTION?

_____

HAVE YOU NOTICED THAT PEOPLE TEND TO MUMBLE? YES NO
DO YOU SOMETIMES HEAR WORDS, BUT DON'T UNDERSTAND? YES NO

DO OTHERS COMPLAIN THAT THE TELEVISION IS TOO LOUD? YES NO

DO YOU FIND IT DIFFICULT TO HEAR IN NOISY PLACES? YES NO

WHAT OTHER PROBLEMS ARE YOU FINDING?

_____

WHAT IS YOUR PRESENT OCCUPATION? _____

ARE YOU NOW OR HAVE YOU EVER WORKED IN A NOISY PLACE? YES NO

ARE YOU EXPOSED TO NOISE IN ANY OF YOUR PASTIMES OR HOBBIES? YES NO

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name:_____

I acknowledge that I received a copy or Professional Hearing Services, Inc. ‘s Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, the website (if applicable) and I will be offered a copy of and amended Notice of Privacy Practices at each appointment.

- The Notice informs me how Professional Hearing Services, Inc. will use my health information for the purposes of my treatment and/or payment for my treatment.
- The Notice explains in more detail how Professional Hearing Services, Inc. may use and share my health information for other than treatment , payment, and health care operations.
- Professional Hearing Services, Inc. will also use and share my health information as required/ permitted by law.

_____	_____	_____
Patient/ Responsible Party – Please Print	Signature of Patient/ Responsible Party	Date