Annual Updated Information

*** Please complete all questions on the forms****

Personal Information

Patients Name: _____ **Last Four of Social:** _____

Preferred Name: _____ **DOB:**_____/_____/_____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Cell Phone: _____ **Home Phone:** _____ **Work Phone:** _____

Email Address: _____

Gender: ○ **Male** ○ **Female** **Marital Status:** ●**Single** ●**Married** ●**Divorced** ●**Widowed** ●**Child**

Employment Status: ●**Full-Time** ●**Part-Time** ●**Retired** ●**Self Employed** ●**Military**

Employer: _____

How did you hear about our office? _____

Contact Methods (For Privacy)

Emergency Contact Name:_____ **Phone Number:** _____

Relationship to Patient: _____

Please circle <u>all</u> methods in which we may contact you:-

●**Cell Phone** ●**Home Phone** ●**Work Phone** ●**Text** ●**Email** ●**Mail to Home**

Insurance Information

Primary Care Physician: _____

Name of primary cardholder: _____ **Primary's DOB:** _____/_____/____

5607 114th Street, Ste. 100
Lubbock, Texas 79424
info@myhearingdoc.com myhearingdoc.com P: 806-798-3600 F:806-798-3601

Policies

Please read through our policies and initial on the highlighted lines provided.

We ask that all office visits and services be paid at the time they are provided. Although we will gladly bill your insurance when possible, **you will be responsible for any unpaid balance left by your insurance.**

Initial Here➤_____ ***Policy***

I request that payment of authorized benefits be made on my behalf to The Hearing Doctor for services rendered to me by the provider. I authorize any holder of medical information about me needed to determine these benefits payable for related services to be released to The Hearing Doctor.

Initial Here➤_____ ***Insurance Authorization***

I hereby authorize you to release my medical information needed or requested by my insurance carrier(s), and/or the referring and/or family doctor, and/or school personnel.

Initial Here➤ _____ **Authorization To Release Medical Record**

I hereby authorize the providers and employees of The Hearing Doctor to provide medical treatment/services which includes, but is not limited to, performing and administering tests and diagnostic procedures that are deemed necessary to the licensed providers.

Initial Here➤ _____ **Consent ToTreat**

I acknowledge I have been informed and given the opportunity to read the NOTICE OF PRIVACY PRACTICES (HIPAA) for the office of The Hearing Doctor. I understand a copy of this notice can be made available to me at any time and a copy is always available at the front desk.

Initial Here➤_____ **HIPAA - Acknowledgement of Receipt of the Notice of Privacy Practices**

***Please Note:** We ask that all office visits and services be paid at the time they are provided. We will bill your insurance when possible, leaving any unpaid balance as your responsibility. The payment of authorized benefits on my behalf will be issued to The Hearing Doctor as well as any information necessary to provide services and to process the insurance.*

Signature: _____ **Date:** _____

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(Health Insurance Portability and Accountability Act)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I understand that as part of my health care, The Hearing Doctor originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that this information serves as:

- °A basis for planning my care and treatment,
- °A means of communication among the many health professionals who contribute to my care,
- °A source of information for applying my diagnosis to my bill,
- °A means by which a third party payer can verify that services billed were actually provided, and
- °A tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that and have been provided with a NOTICE OF PRIVACY PRACTICES that provides a more complete description of information uses and disclosures.

I understand that I have the following rights and privileges:

- °The right to review the notice prior to signing this consent,
- °The right to object to the use of my health information for directory purposes, and
- °The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that The Hearing Doctor is not required to agree to the restrictions request.

I understand that I may revoke this consent in writing, except to the extent the organization has already taken action in reliance on theron.

I also understand that by refusing to sign this consent or revoking the consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that The Hearing Doctor reserves the right to change its notice and practices and, prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations, should The Hearing Doctor change its notice, it will send a copy of any revised notice to the address I've provided (whether it is by U.S. Mail or, if I agree, email.

I wish to have the following restrictions to use or disclose my health information:

_____

_____

I understand that as part of this organization's treatment, payment, or health operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent with my signature.

_____ _____

Printed Name **Date**

_____

Signature

_____

For Office Use Only:

( ) Consent received by: _____ on: _____

( ) Consent refused by patient, and treatment refused as permitted.

( ) Consent added to the patient's medical record on _____.

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Cerumen Removal Waiver

Your audiologist may determine that cerumen (i.e., ear wax) needs to be removed from your ear canal. The procedure can be done via irrigation (i.e., water) or manual removal. Due to its potential risks, this procedure should always be performed by a professional. Certain factors can increase the likelihood of complications, such as bleeding and irritation, although complications may still occur without these factors.

I give permission to The Hearing Doctor to remove cerumen from my ears as deemed appropriate. I understand that redness, soreness, and minor bleeding can occasionally occur. The process of ear wax removal can also involve discomfort, temporary hearing loss, and tinnitus. I agree to inform the professional of any blood thinning medications I am currently taking. You have the right to stop the procedure at any time. I agree not to hold the professional or the clinic liable if these symptoms occur.

By signing this consent form, you agree to release The Hearing Doctor from any complications arising from ear wax removal. You affirm that you have the authority, legal capacity, and power to enter into this consent and release, and you will sign any additional documents needed to ensure its full effectiveness. You acknowledge that you have read this consent and release, understand its meaning, and agree that it is binding upon you, your legal representatives, heirs, and assigns.

Note: Medicare does not pay for cerumen removal so you will be responsible for payment. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. If you choose to have this service, by signing this waiver, you should expect Medicare will not pay for the cerumen removal. You have the right to deny this service.

I fully understand and accept the terms of this consent with my signature.

_____ _____

Printed Name **Date**

_____

Signature

For Office Use Only:

( ) Consent received by: _____ on:

_____

( ) Consent refused by patient, and treatment refused as permitted.

( ) Consent added to the patient's medical record on _____.

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