Advanced Hearing Aid Center

904 W. Pennsylvania
Ft. Worth, TX 76104
817-332-8817

Patient Information **Required fields.*

Patient's Name* ______________________________
First Initial Last

Responsible Party (if patient is a child, Parent or Guardian) ______________________________

Address* ______________________________

City* ______________ State* ________ Zip Code* ________

Home Phone ________ Work Phone ________ Mobile Phone ________ Primary: ☐ H ☐ W ☐ M

Date of Birth* ________ Sex*________ Email ________

Marital Status ________ Employment Status ________ Student Status ________

Referring Physician* ________ Primary Physician ________

Is there a place/physician we can send a copy of your test results? ________

Emergency Contact ________ How did you hear about us?* ________

How would you like to receive Appointment Notifications? (circle one) Telephone ___ Email __ Text none

Primary Insurance Information *(if patient is also the insured, enter 'SAME')*

Insured's Name* ______________________________
First Initial Last

Insured Date of Birth* ________

Authorization for Treatment

Audiological care is a service provided in response to a wide range of hearing and balance healthcare needs for patients of all ages, gender, or race. The purpose of audiological care by examination, testing, and procedures is to aid in the diagnosis and treatment, to obtain information needed in diagnosing and examining patients, to prevent or minimize residual physical and mental disability, to aid patients in achieving their maximum potential within their capabilities, and to accelerate convalescence and reduce the length of the functional recovery.

There are certain inherent risks with audiological care. You will be fully informed of any potential risks as the need arises. The audiologist will take every precaution to ensure that you are protected from any potentially harmful situation. You will never be forced to undergo any treatment.

______________________________**(sign & date)**

Office Visits and Office Services-*Payments will be expected at the time of service-*

If you have……	***You are responsible for***
No Insurance/Self-pay:	Full payment is expected at the time of service
HMO, PPO Plans, Discount Plans, Out of Network:	Any office co-pays will be due at appointment; other charges will be billed appropriately after claim is filed
Medicaid, Medicare & Supplements:	We will file all claims with Medicare, Medicaid and supplements.

I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles are my responsibility. Benefits will be paid directly to Advanced Hearing Aid Center/Dr. Tom Roth. I authorize any holder of medical or other information about me to release any information needed to process this or other claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

______________________________**(sign & date)**

Advanced Hearing Aid Center

Hearing Health Questionnaire

Name ____ DOB ______________ Male _____ Female _____

Family history of hearing loss? ____

Do you have dizziness, vertigo, or loss of balance? ___________If yes, explain___________________________

____

Do you have tinnitus? (ringing, buzzing, hissing)_________ Right _____ Left _____ Both _____ Since when? __________

How frequent? ________________________ What is the duration? _________________________

History of exposure to noise? ____

Have you ever worn a hearing aid? _________ How long? _______ Right _____ Left _____ Both _____

Are there any situations where you have the most trouble in hearing? Please list:

1. ____________________________ ____

2. ____

3. ____

4. ____

Medical History: Please check any of the following that you have had or currently have:

Diabetes _____ Heart Disease _____ Stroke _____ High Blood Pressure _____

Arthritis _____ Kidney Disease _____ Cancer _____ Mumps _____

Measles _____ Meningitis _____ Head Trauma _____ Other ___________________________

Please list any medications that you take, including prescription, over the counter, herbals, vitamin/mineral/dietary supplements taken routinely or on an as-needed basis.

Name: Dosage: Frequently taken: Route of administration (ex. Oral)

____

____

____

____

Advanced Hearing Aid Center Patient Authorization for Marketing All Products and Services

To our Patients:

From time to time, our practice would like to tell patients about products and services that we think may be of interest to them. When we give patients promotional gifts of nominal value, or recommend products or services in face-to-face communication, we do not require the patient's written authorization. However, we do require a patient's written authorization before sending other kinds of marketing communications if our practice receives financial remuneration for sending the communications. **If you would like to receive information about products and services from our practice, please complete and sign the authorization form below and return it to us at your convenience.**

Authorization

Patient Name: ____

Patient's Date of Birth: ____

I hereby authorize the practice to use my name and address and other information about my health to provide marketing communications to me. I also authorize the practice to disclose such information to a business associate for purposes of sending marketing communications to me. I understand that the practice may receive financial remuneration for making marketing communications. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations. I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the practice's Privacy Official at the following address:

904 Pennsylvania Ave.
Fort Worth, TX 76104

I understand that if I revoke this authorization, my revocation will not affect any actions taken by the practice before receiving my written revocation. I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits. This authorization expires on the following date, or when the following event occurs: **September 1, 2021**

Signature of Patient or Patient's Personal Representative:

X____ Date _______________________________

If Personal Representative:

Print Name: ____

Signature: ____

Relationship: ____

For Office Use Only

Copy of signed authorization provided to the individual: Date: ____________________ Initials: ______________

Privacy Practices Acknowledgement Form

****You may refuse to sign this acknowledgement**

Patient Name:____ Date of Birth:_________________

Address:____ City/State/Zip:________________

Email:____ Phone:_______________________

- I acknowledge that I have reviewed a copy of Advanced hearing aid Center's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, the website and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.
- This Notice informs me how Advanced Hearing Aid Center will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Advanced Hearing Aid Center may use and share my health information for other than treatment, payment, and health care operations.
- Advanced Hearing Aid Center will also use and share my health information as required/permitted by law.

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I hereby give permission for Advanced Hearing Aid Center to leave messages on:

☐ Cell phone (please initial) _________

☐ Home phone (please initial) _______

☐ Email (please initial) ____________

☐ Work (please initial) ____________

I hereby give the following people permission to receive information on my behalf:

__________________________________ __________________________________

Name of Person Relationship (spouse, mother, friend, etc.)

__________________________________ __________________________________

Name of Person Relationship

__________________________________ __________________________________

Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communications barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (please specify)____