Adirondack Audiology
Hearing and Balance Centers

Patient Information Form

Date: _____

Patient Name: _____ Preferred Name: _____

DOB: _____ Age:_____ Sex:_____

Mailing Address: _____

Physical Address: _____

Home Phone #:_____ Cell Phone #:_____

Work Phone #:_____ E-Mail Address: _____

Marital Status: _____ Spouse Name: _____

Name of Responsible Person: _____

Responsible Person Address (if different than above):_____

_____

Responsible Person Phone# (if different than above):_____

Occupation (if retired, prior occupation):_____

Employer: _____

If Patient is a student what school is patient attending: _____

Emergency contact: _____ Phone #:_____

Relationship to Patient: _____

Primary Care Doctor: _____ Phone #:_____

How did you hear about us? _____

Reason for Appointment: _____

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Insurance Information and Billing Authorization Form

Primary Insurance Carrier: _____ **Member ID#:** _____

Subscriber's Name (if not patient): _____

Subscriber's DOB (MM/DD/YYYY): _____
If Insurance is Employer Sponsored, Employer Name: _____

Secondary Insurance Carrier: _____ **Member ID#:** _____

Subscriber's Name (if not patient): _____

Subscriber's DOB (MM/DD/YYYY): _____
If Insurance is Employer Sponsored, Employer Name: _____

Third Insurance Carrier: _____ **Member ID#:** _____

Subscriber's Name (if not patient): _____

Subscriber's DOB (MM/DD/YYYY): _____
If Insurance is Employer Sponsored, Employer Name: _____

I authorize use of Adirondack Audiology's billing documents on all my insurance submissions, release of information to all insurance companies and payment directly to Adirondack Audiology Associates. I understand that I am responsible for services received from this provider and I do permit a copy of this authorization to be used in place of the original. I authorize any holder of medical or other information about this patient to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers of any information for this or related Medicare claim. I understand it is mandatory to notify the health care provider or any other party who may be responsible for paying any treatments (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides for penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply.

Print Patient Name: _____

Signature of Patient: _____ Date: _____

If patient is under 18 years of age:

Print Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date: _____

Pediatric Case History

Patient Information

Child's Name:		Date:	
Date of Birth:		Age:	

Family History			
Parent related before marriage	Yes No	Family history of kidney disease	Yes No
Family history of thyroid	Yes No	History of progressive blindness	Yes No
History of stillbirth or miscarriages	Yes No	Other children with hearing loss	Yes No
Family history of hearing loss	Yes No	If yes, who?	Age loss was indentified:
Did mother work outside of home during pregnancy?	Yes No	If yes, what type of work and where?	
Did father work outside of home during pregnancy?	Yes No	If yes what type of work and where?	

Maternal Factors			
Drugs taken during pregnancy (included antibiotics)	Yes No	If yes, specify:	
Exposure to chemicals during pregnancy	Yes No	If yes, specify:	
Exposure to radiation / chemotherapy during pregnancy	Yes No	If yes, specify:	
Amniocentesis preformed during pregnancy	Yes No	Rh immunoglobulin given; Rh or ABO incompatible	Yes No
Illnesses during pregnancy	Yes No	If yes, specify:	
Anemia during pregnancy	Yes No	Diabetes during pregnancy	Yes No
Toxemia during pregnancy	Yes No	During pregnancy was mother exposed to :	Chickenpox Measles Mumps German Measles
During pregnancy was mother diagnosed with:	Syphilis Herpes Toxoplasmosis	Influenza Cytomegalovirus (CMV) HIV/Aids Other:	
Any paternal illnesses during pregnancy	Yes No	If Yes, specify:	

Delivery and Labor Factors					
Full-term pregnancy	Yes	No	If no, how many weeks early:		
Was labor induced	Yes	No	Was labor less than 3 hours	Yes	No
Was labor longer than 24 hours	Yes	No	Bleeding	Yes	No
Premature membrane rupture	Yes	No	Forceps delivery	Yes	No
Cesarean section (C-section)	Yes	No			
Other unusual events	Yes	No	If yes, specify:		

Newborn Factors			
Was birth weight less than 5 pounds	Yes	No	If yes, specify birth weight:
APGAR score low at birth	Yes	No	If yes, APGAR score if know:
Placed in intensive care	Yes	No	If yes, specify how long:
Breathing problems at birth	Yes	No	
Oxygen given at birth	Yes	No	
Bilirubin > 15mg/100ml	Yes	No	
Congenital rubella	Yes	No	
Defect of ear, nose, or throat	Yes	No	
Congenital heart disease	Yes	No	
Drugs given (including antibiotics)	Yes	No	If yes, specify:
Exposure to chemicals	Yes	No	If yes, specify:
Paralysis at birth	Yes	No	
Seizures at birth	Yes	No	
Septicemia	Yes	No	

Infant / Childhood Factors					
Eye problems	Yes	No	If yes, specify:		
Balance / gait / dizziness problems	Yes	No	Cerebral palsy	Yes	No
Seizures	Yes	No	Head / Skull injury	Yes	No

Had Child ever been hospitalized for / diagnosed with / treated for:			
Meningitis	Encephalitis	Measles	Influenza
Cytomegalovirus			
Chickenpox	Septicemia	Diabetes	Sickle Cell
Rubella			

History of Ear Problems	
Ear Infections:	None Left Right Both
If yes, specify what ages, how many and how often:	
When was last ear infection?	

Do you have concerns about your child hears:		
Describe:		
Does your child:		
a. Response if you call his/her from another room?	Yes	No
b. Response to his/her name?	Yes	No
c. Try to look toward the sound source when a noise is made?	Yes	No
d. Alter to familiar sounds – i.e., a spoon in a cup?	Yes	No
e. Stop what he/she is doing when there is an unfamiliar sound?	Yes	No

Do you have any concerns about how your child talks?		
Describe:		
Does your child :		
Say at least 10 words?	Yes	No
Say 2-3 word sentences?	Yes	No
Speak clearly to the family?	Yes	No

Do you have concerns about your child's behavior (tantrums, hitting, will not follow directions, etc.) at home or in daycare?
Describe:

Do you notice any problems with your child's general development?		
Describe:		
At approximately what age did your child		
a. Roll over:	b. Sit up:	c. Crawl:
d. Walk:	e. Say his/her first word:	f. Toilet Train

Are there any problems with your child's general health (please include ear infections history) ?
Describe:

Adirondack Audiology
Hearing and Balance Centers

Consent for Use and Disclosure pf Protected Health Information

Notice of Privacy Practices

I hereby give my consent to Adirondack Audiology Associates, P.C. to use and disclose my protected health information (PHI) to carry out treatment, payment, and health care operations (TPO). I have the right to review the Notice of Privacy Practices, prior to signing this consent. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken regarding my care.

Adirondack Audiology Associates, P.C. reserves the right to revise its Privacy Notice Policy at any time. A revised copy may be obtained upon request.

I have the right to request that Adirondack Audiology Associates, P.C. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I _____DOB: _____ acknowledge:

Patient Name (Please Print) (MM/DD/YY)

I have received a current copy of the Notice of Privacy Practices provided by Adirondack Audiology Associates, P.C.

I give my consent to allow Adirondack Audiology Associates, P.C. to use and disclose my protected health information to care out treatment, payment, and healthcare operations.

As the patient, please list below the names and relationship of family members, friends, or caregivers, who have your permission to discuss your medical history and test results. If the patient is a child under the age of 18 years of age, a parent or legal guardian signature is required.

1. _____(relationship)_____Telephone #: _____
2. _____(relationship)_____Telephone #: _____

Signature of Patient _____ Date: _____

Patient under 18 Years of age:

Parent/Legal Guardian Name (Please Print): _____

Consent to Treat Minor

In the case of a patient begin a minor (under the age of 18 years). I hereby give consent to provide diagnostic testing and treatment to the patient. I understand that diagnostic testing and treatment to the patient will be limited to the scope of this practice.

Parent/Legal Guardian Signature: _____ Date: _____

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HIPAA Statement

Notice of Privacy Practices

The notice of Privacy Practices is required by the Privacy Regulations stemming from the Health Insurance Portability and Accountability Act of 1996 (HIPAA). 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.

Our mission is to deliver:

- Effective analysis and diagnosis of your hearing loss or balance condition
- Customized technology solutions that effectively integrated speech comprehension back into your life
- Unsurpassed patient satisfaction
- Excellence through continuing education
- Ongoing investment in the most advance processes, procedures and technology to ensure superior results for each patient
- Our practitioners understand "value" is not measured by price alone. Rather, value is about how well they utilize their knowledge and experience to create a customized solution to meet your hearing expectation and your lifestyle.

According to HIPAA regulations, you have the right to restrict the uses or disclosure of your information made for the purpose of treatment, payment, and /or healthcare operations.

- Treatment is the provision, coordination or management of hearing health care. For example, we may use and disclose your information to consult with a third party or to refer you to other health care providers. We will get your written consent prior to making disclosures outside our practice for treatment purposes, except in emergencies.
- Payment includes the activities necessary to obtain reimbursement for the provision of hearing health care. For example, we may need to give your health plan information about treatment you received at our practice so your health plan will pay us or reimburse you for the treatment. We will get your written consent prior to making disclosures for payment purposes.
- Health care operations include the activities necessary for our practice to run its business operations. For example, we may use your information to review treatment and services and to evaluate the performance of our staff.

If you have any questions regarding our privacy practices or think we may have violated your privacy rights, please contact us at:

Keith Walsh, Au.D.

Owner / Privacy Officer

10 Marsett Road, Suite 3

Shelburne, VT 05482

Telephone #: 802-922-9545

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If your concern is not resolved, you may also submit a written complaint to the US Department of Health and Human Services. If you choose to file a complaint, we will not retaliate in any way.

This practice is determined to protect your medical information. As we provide services to you, we create and store health information (a medical record) that identifies you. It is often necessary to share or disclose this health information in order to provide treatment for you, obtain payment, and to conduct healthcare operations in our office.

This Notice of Privacy Practices requires us to:

1. Keep your medical records private and to provide you with this notice.
2. Update our privacy practices and the term of this notice at any time, ensuring our notice is effective, even for information recently obtained.
3. We reserve the right to make an important change in our privacy practices and change this notice to that effect. You may contact us to request a new copy of our notice and we will make the new notice available upon request.

The following is a description of the different circumstances that may require our practice to use or disclose your medical information:

1. Share medical data with another provider who is responsible for your care (physicians, audiologist, nurses, any other healthcare professional, technicians, students in healthcare, or any other people who take care of you), make referrals and/or placing lab/prescription orders.
2. Share your health insurance plan information about a treatment you received at our practice when filing a claim for reimbursement or determination of benefits.
3. Provide treatment communication concerning treatment alternatives or other health related products or services, unless we or a business associate received financial remuneration on exchange for the communication in which case, we must receive your written authorization unless the communication is made face-to-face or involves gifts of nominal value.
4. Disclose medical information to a medical examiner to identify a deceased person or to determine a cause of death, or for tissue donations.
5. Medical information may be disclosed if you are military personnel, either active or a veteran and if required by the appropriate authorities.
6. Share medical data to the public health and/or law enforcement official whose job is to prevent or control disease, injury, or disability.
7. Share medical data with a representative from the Food and Drug Administration for the purpose of reporting adverse effects stemming from defective products, etc.
8. Medical information may be disclosed when necessary to comply with Workers' Compensation.
9. Medical information may be disclosed in response to a court and/or administrative order in a lawsuit or similar proceeding.
10. In order to contact you for fundraising activities supported by our practice. You have the option to opt out of receiving these communications by sending a written request to the privacy officer.

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11. For marketing purposes for which our practice or our business associates may receive remuneration, for a disclosure that constitutes a sale of protected health information, and in all other situations not described in this policy your written authorization will be obtained before our practice will use or disclose your health information to third parties outside our practice. You have the right to revoke such authorization by providing our practice with a written request to revoke the specific authorization.
12. If a use of disclosure is required by law, the disclosure will be made in compliance with the law and will be limited to such requirements. State and federal laws may be more stringent and may prohibit certain uses and disclosures identified above. When another law is more stringent than HIPAA, we will follow the more stringent requirements.
13. To business associates to perform functions on our practice's behalf, if the business associate has signed an agreement to protect the confidentially of the information.
14. Share information about your condition(s), location and/or death to family member(s), or your personal representative(s). Prior permission by you will be obtained unless in case of emergency. If we are unable to obtain permission, we will share only the health information directly necessary for your health care.

You have the individual rights as part of the Notice of Privacy Practices. As a patient of our practice you have the right to:

1. Request our practice to restrict uses and disclosures of your health information. However, we are not required to agree to the requested restriction unless you are requesting a restriction on the use and disclosure of your protected health information to a health plan for payment or healthcare operations and such information pertains to a healthcare item or service which you paid for in full and out of pocket. These requests should be made in writing to the address given in this Privacy Notice. In your request, you must tell us (a) what information you want to limit; (b) whether you want to limit our use, disclosure, or both, and (c) to whom you want the limit to apply.
2. Be notified upon a breach of any of your unsecured protected health information.
3. Request that we communicate with you regarding your confidential medical information by different means or to different locations. This request must be made in writing to our practice.
4. Request photocopies of your medical records on file and /or a copy of this Notice of Privacy Practices. If you need a photocopy, please notify the front office staff.
5. Request a change to your health information if you think it is incomplete or inaccurate. However, if the audiologist, hearing healthcare professional or office personnel believe that patient's health information is complete and accurate, he/she can refuse to make the requested changes. This request must be made in writing to our practice.
6. Receive a list of all the times your Medical information has been shared by our office or our business associates for six years prior to the request date, other than treatment, payment, health care operations and/or other specified exception.
7. Request a paper copy if you have received this Notice of Privacy Practices electronically. This request must be made in writing to our practice.