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: _____

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PATIENT HISTORY

Patient Name: _____ Date: _____

DOB: _____ Primary Care Physician: _____

Employer: _____ Occupation: _____

What is your primary concern today: _____

How long have you been aware of this difficulty? _____

Is this difficulty due to a work-related injury/exposure? YES / NO

Do you feel your hearing is changing? YES / NO

- If so, do you feel it has been gradual or sudden? GRADUAL / SUDDEN

Have you seen an Ear, Nose and Throat Physician? YES / NO

- If so, who did you see? _____ When? _____

In which situations do you have difficulty hearing? (check all that apply)

_____ in quiet _____ television _____ phone _____ at work

_____ at school _____ in background noise _____ at lectures / worship service / theater

When was your last hearing evaluation? _____

Do you currently wear hearing aids? YES / NO Make / Model: _____

- If yes, are you satisfied with them? YES / NO If no, please explain: _____

On a scale of 0-10, how motivated are you to do something about your communication difficulty?

Not motivated at all 0 1 2 3 4 5 6 7 8 9 10 Highly Motivated

Rank the following in order of importance (1-4), if a hearing aid is recommended for you:

_____ Improved hearing in quiet _____ Improved hearing in noise _____ Expense _____ Cosmetics

Do you have a history of any of the following? If yes, please explan:

Ringing or noises in your ears? YES / NO _____

Dizziness or vertigo? YES / NO _____

Fullness / pressure in your ears? YES / NO _____

Ear infection or ear pain? YES / NO _____

Ruptured ear drum? YES / NO _____

Ear Surgery? YES / NO _____

Family members with hearing loss? YES / NO _____

Taking blood thinners / aspirin? YES / NO _____

Head injury? YES / NO _____

Surgery within the past year? YES / NO _____

Excessive exposure to loud noise? YES / NO _____
(military, hunting, power tools, music, etc.)

Are you in good health? YES / NO

- If no, please explain: _____

Do you have a history of any of the following? Please check all that apply:

____ Asthma	____ Head Injury / TBI	____ Measels	____ Neurological Symptoms
____ Arthritis	____ Heart Disease	____ Meningitis	____ Scarlet Fever
____ Bell's Palsy	____ Heart Trouble	____ Mumps	____ Sinusitis
____ Chemotherapy	____ High Blood Pressure	____ Parkinson's	____ Tuberculosis
____ Diabetes	____ HIV/AIDS	____ Pneumonia	____ Vision Issues
____ Hepatitis	____ Malaria	____ Stroke / TIA	____ Other:

Have you used a tobacco product one or more times in the past 24 months? YES / NO

- If yes, how often have you used a tobacco product in the past 24 months? _____
- If yes, what type(s) of products have you used (cigarette, cigar, smokeless)? _____

Have you ever experienced dizziness, unsteadiness, imbalance or vertigo? YES / NO

- If yes, are you feeling dizzy today? YES / NO
- If yes, please describe: _____

  Frequency of occurrence: _____
- If yes, is it accompanied by: ____ Hearing loss ____ Ringing or noises in your ear

  ____ Nausea ____ Visual disturbances ____ Other: _____

Have you fallen within the past 12 months? YES / NO

- If yes, how many falls have you experienced in the 12 months? _____
- If you have fallen, have you been injured? YES / NO

  Please describe your injury: _____

Do you experience visual difficulties or disturbances? YES / NO

- If yes, please describe: _____

Do you currently take a Vitamin D supplement? YES / NO

Do you currently have a pacemaker? YES / NO

Please list any prescription medications you are currently taking:

Medication	Reason	Dosage	Frequency

What would you like to gain from this evaluation? _____

How did you hear about our facility? _____

TINNITUS HANDICAP INVENTORY

Patient Name: _____ Date: _____

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your tinnitus. Please answer every question. Please do not skip any questions.

1. Because of your tinnitus, is it difficult for you to concentrate?	Yes	Sometimes	No
2. Does the loudness of your tinnitus make it difficult for you to hear people?	Yes	Sometimes	No
3. Does your tinnitus make you angry?	Yes	Sometimes	No
4. Does your tinnitus make you feel confused?	Yes	Sometimes	No
5. Because of your tinnitus, do you feel desperate?	Yes	Sometimes	No
6. Do you complain a great deal about your tinnitus?	Yes	Sometimes	No
7. Because of your tinnitus, do you have trouble falling to sleep at night?	Yes	Sometimes	No
8. Do you feel as though you cannot escape your tinnitus?	Yes	Sometimes	No
9. Does your tinnitus interfere with your ability to enjoy your social activities (such as going out to dinner, to the movies)?	Yes	Sometimes	No
10. Because of your tinnitus, do you feel frustrated?	Yes	Sometimes	No
11. Because of your tinnitus, do you feel that you have a terrible disease?	Yes	Sometimes	No
12. Does your tinnitus make it difficult for you to enjoy life?	Yes	Sometimes	No
13. Does your tinnitus interfere with your job or household responsibilities?	Yes	Sometimes	No
14. Because of your tinnitus, do you find that you are often irritable?	Yes	Sometimes	No
15. Because of your tinnitus, is it difficult for you to read?	Yes	Sometimes	No
16. Does your tinnitus make you upset?	Yes	Sometimes	No
17. Do you feel that your tinnitus problem has placed stress on your relationships with members of your family and friends?	Yes	Sometimes	No
18. Do you find it difficult to focus your attention away from your tinnitus and on other things?	Yes	Sometimes	No
19. Do you feel that you have no control over your tinnitus?	Yes	Sometimes	No
20. Because of your tinnitus, do you often feel tired?	Yes	Sometimes	No
21. Because of your tinnitus, do you feel depressed?	Yes	Sometimes	No
22. Does your tinnitus make you feel anxious?	Yes	Sometimes	No
23. Do you feel that you can no longer cope with your tinnitus?	Yes	Sometimes	No
24. Does your tinnitus get worse when you are under stress?	Yes	Sometimes	No
25. Does your tinnitus make you feel insecure?	Yes	Sometimes	No

FOR CLINICIAN USE ONLY

Total Per Column			
	x4	x2	x0
Total Score	+	+	=

Newman, C.W., Jacobson, G.P., Spitzer, J.B. (1996). Development of the Tinnitus Handicap Inventory. Arch Otolaryngol Head Neck Surg, 122, 143-8.

To interpret the score please refer to the Tinnitus Handicap Severity Scale shown on the reverse side.

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Name: _____ **Date**: _____

Communication Assessment

For the following questions, use the scale, 0 through 10.

0 = I can't hear at all in this situation to

10 = I can hear, and I understand everything in this situation.

1. How would you rate your ability to understand when speaking with another person?

1 2 3 4 5 6 7 8 9 10

2. How would you rate your ability to understand while watching TV and in various types of entertainment? (ex. Movies, Plays, Concerts, etc...)

1 2 3 4 5 6 7 8 9 10

3. How would you rate your ability to understand when conversing with a small group of people? (with family, co-workers, in meeting, or over dinner)

1 2 3 4 5 6 7 8 9 10

4. How would you rate your ability to understand when you are in an unfavorable listening environment? (ex. Noisy party with background music, riding in a car)

1 2 3 4 5 6 7 8 9 10

5. How would you rate your ability to understand, when on a land line telephone?

1 2 3 4 5 6 7 8 9 10

6. How would you rate your ability to understand on a cell phone?

1 2 3 4 5 6 7 8 9 10

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Consent for Use and Disclosure Of 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.