HEARING
Wellness Centers
Certified, Licensed Professional Audiologists

Name: _____ **Date of Birth**: _____

Address: _____ **City**: _____ **State**: _____ **Zip Code**:_____

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

Email:_____

Marital Status: [_] **Single** [_] **Married** [_] **Divorced** [_] **Widowed** **Gender**: ___**Male** ___**Female**
Primary Care Physician: _____ **Referred By**: _____

Emergency Contact:

Name: _____ **Phone**: _____

Relation:_____

Hearing History

Do you have pain/discomfort in your ear(s)? **Yes**: ____**No**: ____

Do you have any drainage in your ear(s)? **Yes**: ____**No**: ____

Do you have ringing or other noises in your ear(s)? **Yes**: ____**No**: ____

Do you have acute or recurring dizziness or vertigo? **Yes**: ____**No**: ____

Do you find yourself asking people to repeat what they have said? **Yes**: ____**No**: ____

Do you find it difficult to hear in noisy places? **Yes**: ____**No**: ____

Have you been told that you speak loudly? **Yes**: ____ **No**: ____

Have you been told that you turn the volume on TV up too loud? **Yes**: ____**No**: ___

When was the first time you noticed difficulty hearing?
_____

Have you had your hearing tested before? Yes: _____ **No**: _____ **When**: _____ **Results**: _____

In which ear is your hearing the worst? Right: _____**Left**: _____**Same**: _____

Do you currently have a hearing aid(s): [_] Yes [_] No

How often do you wear your hearing aid(s)?_____

How old are the hearing aid(s)? : _____

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HIPAA GUIDELINES

The following information is a summary of the NOTICE OF PRIVACY PRACTICES. This notice describes how medical information about you may be used and disclosed and how you can access this information. **PLEASE REVIEW IT CAREFULLY.**

We are required by law to maintain the privacy of your medical information. We must provide you with a copy of this notice. We must follow the terms of this notice. If this notice is changed in any material way, a revised copy will be available upon request.

We will use your medical information for treatment. For example, a nurse who is providing you care will report any condition to your doctor. We will use your medical information about your diagnosis, treatment and supplies used. We may contact you at any phone number or address you have provided to us to remind you of your appointment or other health matters or to obtain payment for services. We may disclose your medical information to your family members you have assigned or other who are involved in your care or payment for that care. You must notify our designee in writing if you do not want us to communicate with you in any of these ways.

We may use your medical information for any uses that are required or permitted by law. Other uses and disclosures will be made only with your written authorization. You have the following rights: Right to privacy notice; Right to request restrictions on uses and disclosures of your medical information; Right to receive confidential communications; Right to inspect and copy your medical information; Right to request an amendment to your medical information; and right to accounting disclosure of your medical information.

If you feel that your privacy rights have been violated, please contact our office at 847-266-8000 or US Secretary of Health and Human Services.

As indicated by my signature below, I hereby acknowledge receipt and understanding of this **Notice of Privacy Practices**.

Signature: _____ Date: _____

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We strive to provide the highest quality healthcare, all the while maintaining affordability for you, the patient. We understand that even with insurance, most patients will experience at least some out of pocket expense.

Participating Insurances

Our office will accept your insurance on assignment and do participate as preferred providers for many insurance plans. However, it must be fully understood that your insurance policy is a contract between you and your insurance. Our office will not enter a dispute with your insurance company over policy limitations or issues**.** This is your responsibility and obligation. All charges incurred are your responsibility. If you have a question or concern with your reimbursement, you will need to contact your insurance company. Our office will file your claims for you and assist you in every way possible to ensure benefit recovery. We will call to verify benefits on your insurance; however , the benefits quoted to us by your insurance company are not a guarantee of payment. **Please understand that it is your responsibility for any non-covered services, deductibles, copays, and or any services denied.**

Patients without Insurance

we request that 100% of the examination be paid at the time of the visit unless other arrangements have been made. We are happy to accept cash, check, all major cards (excluding American Express), HAS/ Flex spending cards. No insurance will be billed.

I have read and understand the Financial Policy Agreement:

Name (Print): _____

Signature: _____ Date: _____

Relationship to patient (if minor): _____