

## NEW PATIENT HISTORY FORM – ADULT

### PATIENT HISTORY

Patient Name: \_\_\_\_\_  Male  Female  
Referral Source: \_\_\_\_\_  
Primary reason for this appointment: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Social Security Number (Optional): \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_  
Email Address: \_\_\_\_\_  
What is the best way to reach you?  Home Phone  Work Phone  Cell Phone  E-mail  Other: \_\_\_\_\_  
Accompanied by: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Business Phone: (\_\_\_\_) \_\_\_\_\_ is it OK to call at work?  Yes  No  
Spouse's Name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Present Physicians: \_\_\_\_\_  
Current Medications: \_\_\_\_\_  
How did you hear about our practice?  Physician  Yellow book  Tallahassee Democrat  Radio  
 Website  Google  Verizon  Yellow Pages  Other: \_\_\_\_\_

### HEALTH INSURANCE INFORMATION

Medicare #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_  
Other Insurances: \_\_\_\_\_  
Responsible Party (Insured): \_\_\_\_\_  
Responsible Party's Birthdate: \_\_\_\_\_  
Employed By: \_\_\_\_\_

## PATIENT CONSENT FOR USE/DISCLOSURE OF HEALTH CARE INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Maiden Name: \_\_\_\_\_

I understand that the patient's health information is private and confidential. I understand that Hearing & Balance Associates works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Hearing & Balance Associates may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care options.

Hearing & Balance Associates has a detailed document called the "Notice of Privacy Practices." It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement, and that I will be given a copy of this "Notice".

Hearing & Balance Associates may update this "Notice of Privacy Practices." If I ask Hearing & Balance Associates for the most recent copy, they will provide it for me.

Under the terms of this consent, I can ask Hearing & Balance Associates to limit how the patient's personal information is used or disclosed to carry out treatment, payment, or health care options. I understand that Hearing & Balance Associates does not have to agree to my request. If Hearing & Balance Associates does agree to my request, I understand that Hearing & Balance Associates would follow the agreed limits.

I may cancel this consent in writing at any time by doing one of the following:

- I. Signing and dating form that Hearing & Balance Associates can give me called "Revocation of Consent for Use and Disclosure of Health Care Information"; or
- II. Writing, signing, and dating a letter to Hearing & Balance Associates. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and health care options.

If I revoke this consent, Hearing & Balance Associates does not have to provide any further health care services to the patient.

My signature below indicates that I have been given the chance to review a current copy of Hearing & Balance Associates "Notice of Privacy Policies." My signature means that I agree to allow Hearing & Balance Associates to use and disclose the patient's personal health information to carry out treatment, payment, and health care options.

Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_

## **INSURANCE AGREEMENT**

Date of Service \_\_\_\_\_

### **AUDIOLOGIST NOTICE**

We will be happy to file your insurance for your hearing evaluation. However, if the insurance company denied payment, the patient is responsible for the balance due.

### **BENEFICIARY AGREEMENT**

I have been notified by my audiologist that his office will file the insurance on my behalf. However, if the insurance company denies payment or it goes to my deductible, I agree to be fully responsible for payment.

### **AUTHORIZATION AGREEMENT**

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

I authorize payment of medical benefits to the undersigned physician or supplier for services rendered.

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

## **NOTICE OF PRIVACY POLICY**

This notice describe how medical information about you may be used and disclosed and how you can get access to this information.

### **PLEASE READ CAREFULLY**

1. **Our Privacy Pledge and Duties** - While we have and always will respect your privacy, a new federal law now requires us to maintain the privacy of hearing health information and other medical information about you and to provide you with a notice of our legal duties and privacy practices with respect to such health information.  
We must abide by the terms of this notice while it is in effect. However, we reserve the right to change terms of our privacy notices. If we change the terms of this notice, we will notify you during your next office visit or by mail.
2. **Disclosure to Relatives, Close Friends and Other Caregivers** – Your hearing health care professional and members of the staff may use or disclose your health information to one of your family members, other relative, a close friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure. If you object to such uses or disclosures, please notify your hearing healthcare professionals.  
If you are not present, you are incapacitated or in any emergency circumstance, we may exercise our professional judgement to determine whether a disclosure is in the best interests. We may also disclose your health information to notify such persons of your location or general condition.
3. **Victim of Abuse, Neglect or Domestic Violence** – If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose health information to a government authority, including social services or protective services agency, authorized by law to receive reports or such abuse, neglect, or domestic violence.
4. **Your Right to Revoke Your Authorization** – You make revoke your authorization to us at any time, however, your revocation must be in writing. There are two circumstances under which we will not be able to honor you revocation request.
  - I. If we have taken an action in reliance upon such authorization before we receive your request for authorization.
  - II. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke you authorization, please write to us at the address given at the top of this notice.
5. **Marketing** - We must also obtain your written authorization prior to using your health information to make your aware of products or services that you might have interest in purchasing from time to time.
6. **Your right to Amend Your Health Information** – You have the right to request that we amend your health information maintained by us. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.
7. **Your Right to Receive an Accounting of the Disclosure We Have Made of Your Records** – You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request, provided such request does not apply to disclosures to disclosures that occurred prior to April 14, 2003. The accounting will include all disclosures except these disclosures:
  - Required to carry out treatment, payment and health care operations to you.
  - That are incident to permitted use of disclosure
  - Made pursuant to an authorization
  - Required to maintain a directory of the individuals in our facility or to individuals involved with your care
  - Required for National Security of intelligence purposes
  - To correctional institutions of law enforcement officers
  - Made as part of a limited data set
  - Made prior to April 14, 2003

If you request accounting more than once during a twelve (12) month period, we will charge one dollar (\$1.00) per page of accounting statement.

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## **ACKNOWLEDGEMENT OF NOTICE OR PRIVACY PRACTICES**

By signing below, I acknowledge that I have received a copy of Hearing & Balance Associates Notice of Privacy Practices. I have read and understand the Notice and I have had an opportunity to ask questions about the use and disclosure of my health information, and other concerns regarding my health information.

Printed Name of Patient \_\_\_\_\_

Signature of Patient \_\_\_\_\_

Date \_\_\_\_\_



DOCTORS OF AUDIOLOGY  
Dr. John H. Koonz, Au. D.  
Dr. Sarah R. Hamman, Au D.

1818 Miccosukee Commons Drive, Tallahassee, FL 32308 | Ph.:850.553.4327 | fax: 850.877.3084 | tallhba@yahoo.com | www.tallhba.com

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have hearing instruments?                      YES                      NO

Do you have ringing in your ears?                      YES                      NO

Do you have dizziness?                      YES                      NO

Do you have feeling of pressure  
or fullness in your ears?                      YES                      NO