

WELCOME TO THE NORTH SIDE AUDIOLOGY GROUP!

Please answer the following questions as completely as possible. Thank you.

Intake Form:

Name: _____ Date: _____
First Last MI

Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Date of Birth: _____

Marital Status Single Married Widowed Domestic Partner

Please send a copy of my test results to:

Referring Physician: _____
First Name Last Name

Street City State Zip Code

Primary Care Physician: _____
First Name Last Name

Street City State Zip Code

Referred by (Circle): Physician Insurance Friend/Family Website Other: _____

Presenting Problem:

1. What is your primary complaint about your ears or hearing? _____

2. What do you think caused your hearing problem? _____

3. If you have a hearing loss, how long have you noticed this? _____

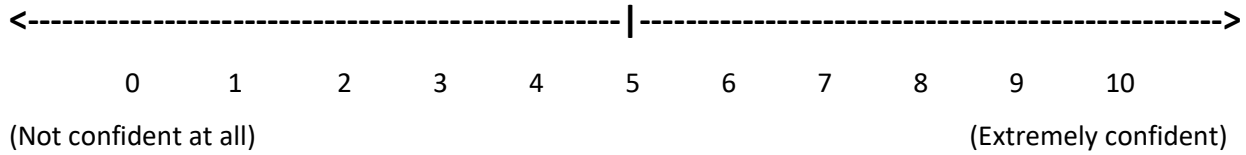
4. Which is your worse ear (if they are different): Left _____ Right _____

12. Have you been treated with chemotherapy? Yes _____ No _____

13. Have you ever worn a hearing aid(s)? Yes _____ No _____

If yes, how would you rate your experience with your hearing aid(s) on a scale of 0 (terrible) to 10 (great)? _____

14. How confident are you in your own ability to use and take care of hearing aids if they are recommended? (Mark on the line)



15. In what situations would you most like hearing aids to help you (if recommended)?:

Conversations with family or friends _____ TV _____ Telephone _____ In the car _____

Places of worship _____ Music _____ Other: _____

16. Select all that apply:

- I am not ready for hearing aids at this time.
- I have been thinking that I might need hearing aids.
- I have started to seek information about hearing aids.
- I am ready to wear hearing aids if they are recommended.
- I am comfortable with the idea of wearing hearing aids.
- I currently wear hearing aids.

Comments or questions for the audiologist:

Medication History:

1. Please list all allergies (food, medication, plastics, etc.):

2. List current medications and dosage:

Notice of Privacy Practices Acknowledgement:

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Policies:

Please read and initial after each policy.

It is the patient's responsibility to confirm if North Side Audiology Group is in network. _____

The patient is responsible for knowing the policies of their insurance, such as copay, coinsurance, deductible, pre-existing conditions, policy exclusions, effective date, termination date, etc. _____

For HMO insurance policies, the patient is responsible for obtaining necessary referrals. _____

Copays and fees for office visit charges are due at the time of services. _____

If the patient is late for the appointment, the appointment may have to be rescheduled. The patient should call to notify the office to check if they can still be seen. _____

If the patient needs to cancel or reschedule, we request at least a 24 hour notice. Cancellations or reschedules less than 24 hours in advance will result in a \$75.00 cancellation fee. _____

Patient Signature: _____ Date: _____

I authorize North Side Audiology Group, Inc. to release information requested with regard to processing my claims. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account and for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify North Side Audiology Group, Inc. of any changes in my health status or in the above information.

Patient Signature: _____ Date: _____

Guardian Signature if Minor: _____ Date: _____