APPLIED HEARING SOLUTIONS

Patient Intake Form

Patient Information:

Name _____
First Middle Last

Address _____
Street City State Zip

Phone _____ _____ **Do you Receive Text Messages?**
Home Cell Yes No

Date of Birth _____ **Email** _____
DD/MM/YY

Marital Status
- ☐ Married
- ☐ Single
- ☐ Partner
- ☐ Widowed

Gender
- ☐ Male
- ☐ Female

Employment Status
- ☐ Full Time
- ☐ Part Time
- ☐ Active Military
- ☐ Not Employed
- ☐ Student
- ☐ Retired

Primary Care Physician _____
Name Clinic City

Referring Physician _____
Name Clinic City

Reason for Visit _____

How did you hear about us?
- ☐ Family
- ☐ Friend
- ☐ Doctor
- ☐ Internet
- ☐ Google
- ☐ Yelp
- ☐ Insurance
- ☐ Facebook
- ☐ In & Out Magazine
- ☐ YouTube
- ☐ Other

Who can we thank for telling you? _____

Emergency Contact _____

APPLIED HEARING SOLUTIONS

Name Relationship Phone #

Responsible Party _____

Name Relationship Phone #

If patient is under 18 years, please complete the section below:

Parent/Guardian _____

Name Relationship Phone #

Financial Agreement:

We participate in several different insurance plans including Medicare. We will file your claims for companies with whom we are contracted with. For insurance plans that we are not contracted with, we will provide you with the necessary documents, requested by the insurer, so you may file an out-of-network claim for reimbursement. You are financially responsible for any equipment or services that are not covered by your insurance. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance companies. You will be responsible for co-payment, deductibles, out-of-network amounts or any portion not reimbursed by your insurance plan. Payment for co-pays, co-insurance, and any deductibles are expected at the time of service. If any fee is not covered by insurance, it is your responsibility. All fees for technology or services are expected at the time the service is rendered. Financing is available for those who qualify.

Authorization to contact by mail, phone, or email:

I hereby authorize Applied Hearing Solutions to contact me by mail, email, or phone, to inform me of scheduled appointments, follow-up appointments or to keep me updated on technological and service advances in the hearing field.

Assignment of Insurance Benefits:

I hereby authorize direct payment to Applied Hearing Solutions of any insurance or health benefits otherwise payable to or on behalf of the patient for examination, treatment or devices delivered to me by Applied Hearing Solutions, at the rate not to exceed Applied Hearing Solutions' usual charges. I understand that verification of insurance coverage obtained over the phone or online is estimated and does not guarantee payment and that insurance coverage is a relationship between the patient and his or her insurance company(s). I agree to accept financial responsibility for any charges for goods and services rendered to the patient that are not covered by insurance or health benefit plan pursuant to this assignment of benefits. I have been informed that Medicare does not provide payment for hearing aids, other assistive listening devices or fitting examinations.

Financial Responsibility Agreement, Authorization to contact, and Assignment of Insurance Benefit by Patient or Legal Representative:

I agree to accept financial responsibility for the goods and services rendered to the patient and to accept the terms of the Authorization to contact, and Assignment of Insurance Benefit provisions listed above.

I have read and agree to these terms.

Signature of Patient or Legal Representative _____ Date _____

Signature of Insurance Policy Holder _____ Date _____

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name _____

I hereby authorize the following person(s) to receive information on the status of personal health information on the above named patient verbally or written and that the following people may speak on my behalf to Applied Hearing Solutions.

_____	_____	_____
Name	Relationship	Phone #
_____	_____	_____
Name	Relationship	Phone #
_____	_____	_____
Name	Relationship	Phone #

I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____	_____
Signature of patient or legal representative	Date
_____	_____
Signature of witness (office staff only)	Date

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment of alcohol and drug abuse. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Applied Hearing Solutions at 4045 E Union Hills Dr Suite D128 Phoenix, AZ 85050. I understand that the revocation will not apply to information that had already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this health information is voluntary. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 165.524. If I have questions about disclosures of my health information I can contact Applied Hearing Solutions at (602)877-0000 or email Answers@AppliedHearingAZ.com.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

I acknowledge that I had the opportunity to review a copy of Applied Hearing Solutions' Notice of Privacy Practices located on the clipboard behind this document. I further acknowledge that I may request a paper copy of Applied Hearing Solutions' Notice of Privacy Practices, or view it any time at www.AppliedHearingAZ.com, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

- This Notice informs me how Applied Hearing Solutions will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Applied Hearing Solutions may use and share my health information for other than treatment, payment, and health care operations.
- Applied Hearing Solutions will also use and share my health information as required/permitted by law.

_____ _____

Signature of patient or personal representative Date

_____

Printed name of patient or personal representative

Notice of Privacy Practices

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.

ABOUT THIS NOTICE

Applied Hearing Solutions is committed to protecting your health information. This Notice of Privacy Practices ("Notice") is provided pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as revised in the 2013 HIPAA Omnibus Rule. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or audiological/health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights and our duties with respect to your protected health information.

"Protected health information" is information about you that may identify you and that relates to your past, present or future physical or mental health/condition and related audiological/health care services. We must follow the privacy practices that are described in this Notice while it is in effect. If you have any questions about this Notice, please contact us at (602)877-0000 or Answers@AppliedHearingAZ.com.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe the different ways that we may use and disclose your protected health information. These examples are not meant to be exhaustive, but to illustrate the types of uses and disclosures that may be made.

1. Treatment

We may use and disclose your protected health information to provide, coordinate, or manage your audiological treatment and any related services. We may also disclose your protected health information to other third party providers involved in your audiological/health care. For example, your protected health information may be provided to a physician or other audiological/health care provider (e.g. a specialist or laboratory) to whom you have been referred to ensure that the physician or other audiological/health care provider has the necessary information to diagnose or treat you.

2. Payment

We may use and disclose your protected health information so that the treatment and health care services you receive may be billed to you, your insurance company, a government program, or third party payors. This may include certain activities that your health insurance plan may undertake before it approves or pays for the audiological/health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may provide your health plan with medical information about the audiological/health care services Applied Hearing Solutions rendered to you for reimbursement purposes.

3. Audiological/Health Care Operations

We may use and disclose your protected health information for audiological/health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and for our operation and management purposes. For example, we may use your protected health information to review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to audiologists, physicians, nurses, technicians, medical students, and other personnel for educational and learning purposes.

4. Treatment Communications

We may provide treatment communications concerning treatment alternatives or other health related products or services. For communications for which we or a business associate may receive financial remuneration in exchange for making the communication, we must obtain written authorization unless the communication is made face-to-face and/or involving promotional gifts of nominal value. If you do not wish to receive these communications please submit a written request to Dr. Clifford R. Olson at 4045 E Union Hills Dr. Suite D128 Phoenix, AZ 85050 or Answers@AppliedHearingAZ.com.

5. Fundraising Activities

We may use or disclose your demographic information and dates of services provided to you, as necessary, in order to contact you for fundraising activities supported by Applied Hearing Solutions. You have the right to opt out of receiving fundraising communications. If you do not want to receive these materials, please submit a written request to Dr. Clifford R. Olson at 4045 E Union Hills Dr. Suite D128 Phoenix, AZ 85050 or Answers@AppliedHearingAZ.com.

6. Others Involved in Your Healthcare

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. Also, for example, if you are brought into this office and are unable to communicate normally with your clinician for some reason, we may find it is in your best interest to give your hearing instrument and other supplies to the friend or relative who brought you in for treatment. We may also use and disclose protected health information to notify such persons of your location, general condition, or death. We also may coordinate with disaster relief agencies to make this type of notification. We also may use professional judgment and our experience with common practice to make reasonable decisions about your best interests in allowing a person to act on your behalf to pick up your hearing instruments, supplies, records, or other things that contain protected health information about you.

7. Required by Law

We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

8. Public Health

We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

9. Business Associates
We may disclose your protected health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. To protect your health information, however, we require the business associate to appropriately safeguard your information.
10. Communicable Diseases
We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
11. Health Oversight
We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies
seeking this information include government agencies that oversee the audiological/health care system, government benefit programs, other government regulatory programs and civil rights laws.
12. Abuse or Neglect
We may disclose your protected health information to a public health authority that is authorized by law to receive reports of abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
13. Food and Drug Administration
We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required by law.
14. Legal Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request or other lawful process.
15. Law Enforcement
We may disclose your protected health information, so long as applicable legal requirements are met, for law enforcement purposes.
16. Coroners, Funeral Directors, and Organ Donation
We may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose your protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out its duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.
17. Research
We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
18. Serious Threat to Health or Safety

Consistent with applicable federal and state laws, we may disclose your protected health information to prevent or lessen a serious threat to your health and safety or to the health and safety of another person or the public.

19. Military Activity and National Security

If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your protected health information to authorized officials so they may carry out their legal duties under the law.

20. Workers' Compensation

We may disclose your protected health information as authorized for workers' compensation or other similar programs that provide benefits for a work-related illness.

21. For Data Breach Notification Purposes

We may use or disclose your protected health information to provide legally required notices of unauthorized access to or disclosure of your health information.

22. Required Uses and Disclosures

Under the law, we must make disclosures to you and when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. Seq.

SPECIAL PROTECTIONS FOR HIV, ALCOHOL AND SUBSTANCE ABUSE, MENTAL HEALTH AND GENETIC INFORMATION

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. Some parts of this Notice may not apply to these types of information.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION

The following uses and disclosures will be made only with your written authorization:

1. Uses and disclosures of protected health information for marketing purposes for which we or a business associate may receive remuneration; and

2. Disclosures that constitute a sale of protected health information.

Other uses and disclosures of your protected health information not described in this Notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent that Applied Hearing Solutions has taken an action in reliance on the use or disclosure indicated in the authorization. Additionally, if a use or disclosure of protected health information described above in this Notice is prohibited or materially limited by other laws that apply to use, it is our intent to meet the requirements of the more stringent law.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

1. Right to be Notified if there is a Breach of Your Protected Health information

You have the right to be notified upon a breach of any of your unsecured protected health information.

2. Right to Inspect and Copy

You may inspect and obtain a copy of your protected health information that is contained in your medical and billing records and any other records that Applied Hearing Solutions uses for making decisions about you. To inspect and copy your medical information, you must submit a written request to Dr. Clifford R. Olson at 4045 E Union Hills Dr. Suite D128 Phoenix, AZ 85050 or Answers@AppliedHearingAZ.com. If you request a copy of your information, we may charge you a reasonable fee for the costs of copying, mailing or other costs incurred by us in complying with you request. Under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, we may deny your request to inspect and/or copy your protected health information. A decision to deny access may be reviewable. Please contact Applied Hearing Solutions at (602)877-0000 or Answers@AppliedHearingAZ.com. if you have questions about access to your medical record.

3. Right to Request Restrictions

You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. To request a restriction on who may have access to your protected health information, you must submit a written request to Dr. Clifford R. Olson at 4045 E Union Hills Dr. Suite D128 Phoenix, AZ 85050 or Answers@AppliedHearingAZ.com. Your request must state the specific restriction requested and to whom you want the restriction to apply. Applied Hearing Solutions is not required to agree to a restriction that you may request, unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment or audiological/health care operation purposes and such information you wish to restrict pertains solely to a audiological/health care item or service for which you have paid us "out-of-pocket" in full. If we believe it is in your best interest to permit the use and disclosure of your protected health information, your protected health information will not be restricted. If we do agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

4. Right to Request Confidential Communication

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. You must request this by submitting a written request to Dr. Clifford R. Olson at 4045 E Union Hills Dr. Suite D128 Phoenix, AZ 85050 or Answers@AppliedHearingAZ.com.

5. Right to Request Amendment

You may request an amendment of your protected health information contained in your medical and billing records and any other records that Applied Hearing Solutions uses for making decisions about you, for as long as we maintain the protected health information. You must request for an amendment by submitting a written request to Dr. Clifford R. Olson at 4045 E Union Hills Dr. Suite D128 Phoenix, AZ 85050 or Answers@AppliedHearingAZ.com, and provide the reason(s) that support your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

6. Right to an Accounting of Disclosures

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. You must request for an accounting of disclosures by submitting a written request to Dr. Clifford R. Olson at 4045 E Union Hills Dr. Suite D128 Phoenix, AZ 85050 or Answers@AppliedHearingAZ.com, and provide the reason(s) that support your request.

7. Right to Obtain a Paper Copy of this Notice

You have the right to receive a paper copy of this Notice even if you have agreed to receive this notice electronically. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this Notice, you can contact Applied Hearing Solutions at (602)877-0000 or Answers@AppliedHearingAZ.com. You may also obtain a copy of this Notice at www.AppliedHearingAZ.com.

COMPLAINTS OR QUESTIONS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. If you have a question about this Notice or wish to file a complaint with us, please contact Applied Hearing Solutions at (602)877-0000, Answers@AppliedHearingAZ.com, or Dr. Clifford R. Olson at the address listed below. All complaints must be submitted in writing. Applied Hearing Solutions will not retaliate against you for filing a complaint.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time. The new Notice will be effective for all health information we already have about you as well as any information we receive in the future. You can also obtain a revised Notice at www.AppliedHearingAZ.com or by contacting Dr. Clifford R. Olson at 4045 E Union Hills Dr. Suite D128 Phoenix, AZ 85050 or Answers@AppliedHearingAZ.com, or (602)877-0000

Applied Hearing Solutions
Attn: Dr. Clifford Olson

This Notice is effective as of May, 2017.