Rensselaer
2 Empire Drive, Suite 204
Rensselaer, NY 12214
518-283-6111

Hudson
351 Fairview Ave., Ste 350
Hudson, NY 12534
518-283-6111

Queensbury
118 Quaker Road
Queensbury, NY 12804
518-798-6428

Patient Information Form

Date__________

Name: ___________________________________ DOB: _______________

Legal Guardian if Under 18: ____

Street Address: ____

City: __________________________ State: ____________ Zip: ___________

Home Phone: ________________ Cell Phone: _________________ Work: ______________

Email Address: _______________________________________

Emergency Contact: _____________________ Emergency Contact Phone: ______________

Circle all that apply: Married Widowed Single Divorced Student Employed Retired

Circle one: MALE FEMALE

Primary Care Physician: __________________________ Phone Number: _______________

ENT Physician: _________________________________ Phone Number: _______________

Who referred you to our practice: (please circle all that apply:)

Friend	Primary care Doctor	ENT Physician	Walk-in
Website	Health/Senior Fair	Employer	Phone book
Newspaper	Attended Seminar	Mail	Television

Radio Other: ____________________ Name of Person: _________________

MEDICATIONS: (If you have a list of current medications, please give to front office staff to make a copy)

____
____
____

General History:

Primary reason for appointment:	**Hearing Loss**	**Tinnitus**	**Sound Sensitivity**	**Other**
Secondary reason for appointment:	**Hearing Loss**	**Tinnitus**	**Sound Sensitivity**	**Other**

Patient Signature: _______________________________ Date: _________________________

Audiologic Solutions
HEARING AND WELLNESS CENTER
www.audiologicsolutions.net

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Case History Form

Name ______________________________ Age ________ DOB __________

Referred by: ______________________________ Today's Date: ______________

1. How would you best describe you hearing?
   - ○ Hearing is fine with no concerns
   - ○ Difficulty hearing in noisy environments
   - ○ Difficulty hearing in group situations
   - ○ Able to hear but not clearly
   - ○ Difficulty hearing from a distance
   - ○ Unable to hear

2. Do you feel that your hearing is better in one ear? YES NO
   If YES, which ear is better? ○ Right ○ Left

3. Have you previously had a diagnostic hearing test? YES NO
   If YES, how long ago? ____________ Results? ______________

4. Have hearing aids ever been recommended? YES NO
   Do you currently wear hearing aids? YES NO
   How long have you used hearing aids? ________ Age of your current aids? ________
   Any concerns with your current aids? ______________________________

5. Do you ever experience tinnitus? YES NO
   Is it bothersome? YES NO
   Which ear? ○ Right ○ Left

6. Are you overly sensitive to sound? YES NO
   Is it bothersome? YES NO
   What type of sounds? ______________________________
7. Do you have a history of ear infections? YES NO
8. Have you ever had ear surgery? YES NO
9. Is there a family history of hearing loss? YES NO
10. Have you ever been exposed to loud noise, recently or in the past?
    - ○ Firearms
    - ○ Music
    - ○ Motorcycles/Recreational Vehicles
    - ○ Factory work
    - ○ Farm equipment
    - ○ Military equipment
    - ○ Explosions
    - ○ Power tools
    - ○ Heavy equipment

Please check (√) if you have **experienced** any of the following:

- ○ Excessive earwax
- ○ Ear pressure/fullness
- ○ Fluctuating hearing loss
- ○ Ear drainage/bleeding
- ○ Popping sensation of the ear
- ○ Fluid behind the eardrum
- ○ Swimmer's ear
- ○ Ear pain
- ○ Dizziness/Vertigo
- ○ Other ________

Please check (√) if you have been **diagnosed** with any of the following:

- ○ Otosclerosis
- ○ Labyrinthitis
- ○ Permanent hearing loss
- ○ Bell's palsy
- ○ Cholesteatoma
- ○ Meniere's disease
- ○ Ossicular dislocation/fixation
- ○ Sudden hearing loss
- ○ Barotrauma
- ○ Acoustic neuroma

Medical History:

Please check (√) if you have **experienced** any of the following:

- ○ Heart disease
- ○ Stroke/TIA
- ○ High blood pressure
- ○ Mental illness
- ○ Depression or anxiety
- ○ Migraines
- ○ Meningitis
- ○ HIV/AIDS
- ○ Visual problems
- ○ Chronic sinus infections
- ○ Cancer
- ○ Radiation
- ○ Chemotherapy
- ○ Long term IV antibiotics
- ○ Loss of consciousness
- ○ Exposure to chemicals/solvents
- ○ Diabetes

Using a 1 – 10 scale, how motivated are you to improve your hearing?

1 ———————— 5 ———————— 10

What are your expectations of today's appointment?

____

____

Would you like a copy of today's audiogram? YES NO

I have answered these questions accurately and to the best of my ability:

______________________________ __________

Signature of Patient/Legal Guardian Date

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Policy Statements

Privacy Policy: I understand that Audiologic Solutions Privacy Policy (HIPAA) is available to me and that I may have a copy.

Initial:__________

Authorization For Release Of Information: I authorize the release of information to my doctor or Audiologist, and physicians involved in my care, as well as to my insurance company to process any medical claims.

Initial:__________

Consent: I authorize Audiologic Solutions and any qualified authorized people employed by them to perform and/or initiate medical or diagnostic evaluation, treatment, related services or agreed upon products on my behalf.

Initial:__________

Communication: I understand that as part of my hearing healthcare, Audiologic Solutions will need to contact me to remind me of an appointment, provide test results, give instructions, or provide other information. I have indicated my preferred method of contact on the intake form.

Initial:__________

Photo ID: Due to government regulations regarding insurance fraud and mistaken identity, patients and/or guardians may be asked for a driver's license or other form of photo identification.

Initial:__________

My protected health information may be disclosed to the following (i.e. family):

____

____

My signature below acknowledges that I understand and have agreed to the above listed policies:

________________________________ ______________

Signature of Patient/Legal Guardian Date

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Advance Beneficiary Notice of Non-Coverage (ABN)

Patient Name: ____________________________ **Date:**______________________

NOTE: If your insurance doesn't pay for any procedures listed below, you may have to pay. Insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance may not pay for the items listed below, but any recommended procedure will be discussed with you, along with any possible costs.

PROCEDURES	REASON INSURANCE MAY NOT PAY
1. Earmolds (if needed) 2. Cerumen Removal (if needed) 3. Tinnitus Retraining 4. Routine Testing 5. Hearing aid services if not under a service plan (cleaning, reprogramming, verification).	1. Insurance/Medicare may deem as a non-covered service. 2. Insurance does not cover this procedure when performed by a licensed audiologist. 3. This item may be statutorily excluded. 4. Some insurances do not cover routine testing. 5. This is a non-covered service.

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive any procedures listed above.

OPTIONS: **Check only one box. We cannot choose a box for you.**
☐ **OPTION 1.** I want the procedure(s) listed above. Your insurance will be billed for an official decision on payment. I understand that if my insurance doesn't pay, I am responsible for payment, but I can appeal to my insurance company. If my insurance does pay after appeal, any payments I made will be refunded, less co-pays or deductibles. ☐ **OPTION 2.** I want the procedure(s) listed above, but do not bill my insurance. I am responsible for payment. I cannot appeal if my insurance is not billed. ☐ **OPTION 3.** I don't want any procedure(s) that may be recommended from the list above.

Additional Information: Any services we recommend that may have an out-of-pocket expense, we will discuss with you first and obtain confirmation before proceeding. Signing below means that you have received and understand this notice. You may also receive a copy.

Signature:	**Date:**