Hearing Health Report

Hears 2 You

OUR INQUIRY, OBSERVATION AND HEARING TEST RESULTS FOR:

Patient's Name _____ Today's Date _____

Gender: ☐ Male ☐ Female Phone _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Email _____ Occupation _____ ☐ Past ☐ Present

Marital Status ☐ Single ☐ Married ☐ Widowed Name of Spouse _____

Name of Observing Party _____ Relationship _____

Name of Family Physician _____

Permission to release a copy of test information to family physician ☐ Yes ☐ No

Insurer Name _____ Insurer Phone _____

Insurance ID No. _____ Insurance Group No. _____

How did you hear about us? ☐ Mail ☐ Newspaper ☐ Google ☐ Physician ☐ Insurance ☐ Friend ☐ Other _____

Hearing Health History

Do you have any allergies? ☐ Yes ☐ No If yes, please list _____

Are you an insulin-dependent diabetic? ☐ Yes ☐ No

Are you currently taking any medications? ☐ Yes ☐ No If yes, please list _____

Do you have arthritis? ☐ Yes ☐ No

Do you have any ringing in your ears? ☐ Yes ☐ No If yes, which ear? _____

Have you been exposed to loud sounds in your life? ☐ Yes ☐ No If yes, please describe? _____

Have you previously had a hearing test? ☐ Yes ☐ No If yes, by whom? _____ Date _____

Have you received any medical or surgical treatment for a hearing loss? ☐ Yes ☐ No If yes, when? _____

Physician/ENT _____ Phone _____

Additional Information about treatment: _____

Patient HIPPA Consent, Insurance and Payment

I understand that I have certain rights to privacy regarding my protected health information according to the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize the clinic to use and disclose my protected health information for the purpose of:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment):
- Obtaining payment from insurance or third-party benefit plans:
- The day-to-day healthcare operations of the clinic such as quality assessments and provider certifications.

Insurance and Payment

I authorize the clinic to provide medical treatment and file my insurance and third-party benefit claims. I authorize payments of medical benefits to be paid directly to the clinic. I understand that I am financially responsible to the organization of any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied payment.

I accept full responsibility for all charges in the event that I have no insurance or third-party benefits.

Patient Signature or Legal Custodian _____ Date _____

Communication Assessment

Listening Environments	How well do you currently hear in this listening environment?			How frequently are you in this listening environment?		
	WELL	FAIR	POOR	OFTEN	SOMETIMES	RARELY
One on One Conversations	○	○	○	○	○	○
Quiet Room (1-2 People)	○	○	○	○	○	○
Small Groups (3-6 People)	○	○	○	○	○	○
Large Social Gatherings	○	○	○	○	○	○
Watching TV	○	○	○	○	○	○
During Religious Services	○	○	○	○	○	○
Meetings	○	○	○	○	○	○
In the Car	○	○	○	○	○	○
Outdoors	○	○	○	○	○	○
On the Telephone	○	○	○	○	○	○

Amplification History

Are you a current hearing aid wearer? ☐ Yes ☐ No Type _____ Ear Fitted: ☐ Both ☐ Left ☐ Right

How long have you worn hearing aids? _____

If yes, and you could improve something about your current hearing instruments, what would that be? _____

What type of cell phone do you have? _____

FOR OFFICE USE ONLY

FDA Questions

- Visible congenital or traumatic deformity of the ear? ☐ Yes ☐ No
- Visible evidence of significant cerumen accumulation or a foreign body in the ear canal? ☐ Yes ☐ No
- Any history of, or active drainage from the ear within the past 90 days? ☐ Yes ☐ No
- Any history of sudden or rapidly progressive hearing loss within the previous 90 days? ☐ Yes ☐ No
- Have you experienced any acute or chronic dizziness? ☐ Yes ☐ No
- Is there a unilateral hearing loss of sudden or recent onset within the past 90 days? ☐ Yes ☐ No
- Have you experienced any pain or discomfort? ☐ Yes ☐ No
- Audiometric air-bone gap equal to or greater than, 15dB at 500 Hz, 1000 Hz and 2000 Hz? ☐ Yes ☐ No

If the answer is "Yes" to any of these questions, patients must be referred to a physician or ear specialist prior to a hearing instrument fitting.

Notes: _____

Health Insurance Benefits / coverage / authorizations DISCLAIMER:

As a courtesy Palmetto Hearing Care Center / Hears 2 You, LLC will attempt to verify your health insurance benefits, and / or obtain necessary authorizations for your services. Please be aware, this is only a *Quote* of your healthcare benefits provided to us by your insurance company but is *not a guarantee of payment*. *We cannot guarantee payment or verify that definite eligibility of benefits conveyed to us or to you by your carrier will be accurate or complete. Payment of benefits are subject to all terms, conditions, limitations and exclusions of the member's contract at the time of service.* We file insurance as a courtesy to our patients.

In most cases, your insurance will only pay for services that it determines to be reasonable and necessary. Our office will make every effort to bill your insurance company in a timely manner. If your carrier determines that a particular service is not reasonable and/ or necessary, or that a particular service or diagnosis is not covered under your plan, your insurance will deny coverage for the service and the billed charges will become your responsibility.

We strongly recommend, request and encourage you to be familiar with, and verify, your own benefits with your insurance company prior to being seen in our office. Please also be aware of any deductible amounts that may interfere with your out of pocket expenses for services.

I understand that Palmetto Hearing Care Center/ Hears 2 You, LLC will bill my insurance company. I understand that all co-pays are due on the date of service. I understand that I am responsible for all deductible and co-insurance amounts that will likely be billed to me after an EOB is received after services are rendered. I understand that it is my financial responsibility to pay the balance due within 30-days of receiving the bill. If my insurance company denies service, I am aware and agree that I am financially responsible for my entire balance due.

I understand that if my insurance company requires a referral or pre-authorization for my visit it is my responsibility to obtain this referral from my referring physician or primary care physician prior to my appointment. If my insurance plan has a maximum benefits or limitations on number of visits allowed, I understand it is ultimately my responsibility to keep track of the number of visits permitted and the number I have used.

I understand if I have an unpaid balance to Palmetto Hearing Care Center/ Hears 2 You and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

In order for PHCC/ Hears 2 You or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Palmetto SPOT and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

Please list here anyone who you authorize, in addition to your PCP or referring physician, to receive a report of our findings: ____

_____

My signature below indicates that I have read and understand the items listed above on this page.

Legal signature of or on behalf of patient _____ Date: _____

Thank you for taking the time to read and fill out this paperwork! Thank you for choosing Palmetto Hearing Care Center/ Hears 2 You and Palmetto SpOT!