HEAR IN TEXAS

PATIENT REGISTRATION FORM

Date: _____ /_____ /_____

Patient Name: _____ Title: Mr. Mrs. Ms. Dr.

D.O.B _____ /_____ /_____ Marital Status: Married Single Divorced Widowed

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Work Phone: _____ Other Phone: _____

Email Address: _____ May we contact you by email? Yes No

Occupation: _____ Employer: _____

How did you hear about us? ☐ TV ☐ Newspaper ☐ Mailer ☐ Magazine ☐ Radio ☐ Yellow Pages

☐ Internet ☐ Facebook ☐ Referred by a Friend/Relative _____

☐ Other _____

Do you give our practice permission to speak to a family member about your health care? ☐ Yes ☐ No

If so, who? _____ Initial: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____ Facility: _____

Address: _____ Phone: _____

May we report the results of your visit to your primary care physician? Yes No

Primary Insurance Company (s): _____ ID Number: _____

Subscribers Name: _____ DOB: _____ Phone (if different): _____

Secondary Insurance Company (s): _____ ID Number: _____

Subscribers Name: _____ DOB: _____ Phone (if different): _____

Relationship to patient: Self Spouse Child Other _____

Subscriber Employer: _____ Employer Address: _____

Have you ever served in the military? ☐ No ☐ Yes Do you currently receive VA benefits? ☐ No ☐ Yes

Are your injuries, accident or work related? ☐ No ☐ Yes Are you covered by workman's compensation? ☐ No ☐ Yes

ADULT REGISTRATION

Patient Name: _____ DOB: ____/____/____

Reason for today's visit: _____

Have you ever had a hearing test? If so, where and when? _____

Please check all that apply:

Hearing Loss..... ☐ Right Ear ☐ Left Ear ☐ Both Ears

Tinnitus (Noise/Ringing) In Ears..... ☐ Right Ear ☐ Left Ear ☐ Both Ears

Ear Pain..... ☐ Right Ear ☐ Left Ear ☐ Both Ears

Chronic Wax Build-Up..... ☐ Right Ear ☐ Left Ear ☐ Both Ears

Chronic Ear Infections In Past..... ☐ Right Ear ☐ Left Ear ☐ Both Ears

Perforated Ear Drum..... ☐ Right Ear ☐ Left Ear ☐ Both Ears

Ear Surgery..... ☐ Right Ear ☐ Left Ear ☐ Both Ears

Ear Drainage Within last 90 days..... ☐ Right Ear ☐ Left Ear ☐ Both Ears

Sudden or Rapidly Changing Hearing Loss Within last 90 days..... ☐ Right Ear ☐ Left Ear ☐ Both Ears

Noise Exposure..... ☐ Gunfire ☐ Machinery ☐ Loud Music ☐ Other _____

Are you a smoker?..... ☐ No ☐ Yes ☐ I quit, date: _____

Family Members with Hearing Loss..... ☐ No ☐ Yes _____

Chemotherapy in the past..... ☐ No ☐ Yes _____

Dizziness..... ☐ No ☐ Yes _____

Please describe your dizziness: ☐ Spinning ☐ Off-Balance ☐ Lightheadedness ☐ Motion Provoked

Is your dizziness accompanied by: ☐ Vomiting ☐ Nausea ☐ Ear Noises

Have you had two or more falls in the past 12 months OR 1 fall with an injury? ☐ No ☐ Yes

Have you ever had vestibular testing or rehabilitation? ☐ No ☐ Yes

Do you currently wear hearing aid/s? ☐ No ☐ Right Ear ☐ Left Ear ☐ Both Ears

Where did you purchase your hearing aid/s? _____

Is it under manufacturer warranty? _____

Have you ever been diagnosed with any of the following medical conditions?

☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Bleeding Disorder ☐ Kidney Disease

☐ Cancer ☐ Vertigo ☐ Meniere's Disease ☐ Arthritis ☐ HIV ☐ Dementia ☐ Genetic Disorders

☐ Eye Problems _____ ☐ Other (List:) _____

List: _____

Please list current medications, including over the counter: _____

_____

_____

Patient Name: _____

PATIENT CONSENT

CLINICAL

I authorize Hear In Texas, Inc. to perform all recommended/referred diagnostic procedures. I further authorize Hear In Texas, Inc. to complete all measures needed to make a thorough diagnosis and recommendation. I authorize that such diagnostic material may be released to third-party payors and/or other health professionals.

INSURANCE

I authorize Hear In Texas, Inc. to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records and other diagnostic material about my medical history, services rendered, or recommended treatment. I authorize Hear In Texas, Inc. to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company on my behalf and in my name listed as "signature on file"

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that Hear In Texas, Inc. provided me with a written copy of its Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Signature: _____ Date: _____

No-Show Policy

We at Hear In Texas know that schedules can get hectic and that sometimes appointments can't be kept. In those cases, please make sure to let us know at least 24 hours in advance to avoid being charged a $50.00 no-show fee and so that we can devote that time to another patient's healthcare needs.

Patient Signature: _____

Patient Name: _____

FINANCIAL POLICIES

INSURANCE POLICY

In order to better serve you and keep costs down, we find it necessary to define our financial policies. We will gladly file the forms necessary to see that you receive the full benefits of your insurance coverage; however, we cannot guarantee any estimated coverage. Because the insurance policy is an arrangement between you and the insurance company, we ask that patients be directly responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits of your policy. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" fees. Additionally, we are not responsible if your insurance company representative tells us something is covered at X% and later denies payment or pays less than stated. Our involvement will be limited to supplying factual information to facilitate claim processing. If your insurance company has not paid their portion within 60 days from the start of treatment, you are responsible for the payment at that time. All charges are ultimately your responsibility.

REFERRALS

If your insurance requires a referral, it is your responsibility to obtain the referral from your primary care physician before your appointment or your visit will not be covered by insurance and you will be responsible for the payment. Please notify us if your insurance requires pre-authorization for office procedures.
I have read the above and fully understand my financial responsibility.

Signature: _____ Date: _____

COGNITIVE SCREENING POLICY

During your visit a cognitive screening may be performed to establish a baseline for the ear/brain connection. For many this is not only a necessary but an essential portion of the hearing evaluation. Please be aware that this is a non-covered service by insurance companies and is the responsibility of the patient. Our office currently charges $35 for this procedure. We appreciate your cooperation in collecting this fee at the time of service.
I have read the above and fully understand my financial responsibility.

Signature: _____ Date: _____

ROUTINE HEARING EVALUATION POLICY

Several medical insurance plans, including Medicare, do not cover routine hearing evaluations. A hearing evaluation is considered "routine" when no medical ear problem is known or suspected. If you have Medicare and your hearing is being tested for the sole purpose of fitting hearing aids, the exam is not covered. In these scenarios, you are responsible for the charges.
I have read the above and fully understand my financial responsibility.

Signature: _____ Date: _____