PATIENT INFORMATION SHEET

Date_____

Patient's Name_____
Last First Initial

Street Address_____

City_____ State_____ Zip Code_____ Phone No._____

Date of Birth_____ Age_____Sex_____Married/Single_____ Family Doctor_____

Patient's Social Security No._____-_____-_____ Referring Doctor_____

Email Address_____

Patient's Employer_____Phone No._____

Spouse's Name (Parent's name if child)_____

Address if different from above_____ Phone No._____

Spouse or Parent's Employer_____ Phone No._____

Spouse or Parent's Date of Birth_____ Sex_____Married/Single_____

Spouse or Parent's Social Security No._____-_____-_____

Primary Insurance Company Name_____Policy Holder's Birthdate_____

Policy Holder's Name_____ Relationship to Patient_____

Secondary Insurance Company Name_____ Policy Holder's Birthdate_____

Policy Holder's Name_____ Relationship to Patient_____

In case of Emergency Contact_____ Phone No._____

How Did You Hear About Us? (Friend, TV ,Newspaper, Direct Mail, or other)_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize the release of any medical information necessary to process any insurance claims, and I authorize payment of medical benefits directly to the provider of services for myself and / or dependents. I understand I am responsible for any deductibles, co-insurance or amounts for services not covered by the insurance carrier.

Date:_____ Signature:_____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or in my behalf to Saline Audiology Associates, LLC, for any services furnished me by one or more of the said audiologists. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents any information needed to determine these benefits or the benefits payable for related services. In assigned Medicare claims, the audiologist agrees to accept the charge determination of the Medicare carrier as the full charge, and patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the determination of the Medicare Carrier.

Date:_____ Signature:_____

Medical Hearing History

Date_____ Name_____

1. What is your reason for this visit? _____

2. Do you have a family history of hearing loss? YES ____ NO____

3. Do you have ringing or other noises in your ears? YES ____ NO ____

4. If yes, is the ringing constant? **Left Right Both** YES ____ NO ____

5. Do you feel that you hear but do not always understand the words? YES ____ NO ____

6. Do you have trouble hearing in crowds or other noisy situations? YES ____ NO ____

7. Do you or have you ever worked around loud noise? YES ____ NO ____

8. Do you have any noisy hobbies? YES ____ NO____
   If yes, list. _____

9. Do you use firearms? YES ____ NO ____

10. Do you use hearing protection in the presence of loud noise? YES ____ NO ____

11. Do you have a history of a head injury? YES ____ NO____
    If yes, please describe. _____
_____

12. Do you or have you ever experienced dizziness or balance problems? YES ____ NO ____

13. If yes, please describe your dizziness without using the word "dizzy".
_____
_____

14. Did your hearing problem: progress slowly or was it sudden? SLOWLY ____ SUDDEN____

15. Do you suffer or have you suffered from repeated ear infections? YES ____ NO ____

16. Do you have any fullness or pressure in your ears? YES ____ NO____
17. Have you ever had ear surgery? YES ____ NO____
18. Have you ever worn hearing aids? YES ____ NO____
19. Have you had a CT or MRI of the head? YES ____ NO____
    When? _____

20. Circle any of the following that apply:

Low birth weight	Respiratory problems at birth	Measles	Mumps
Meningitis	Illness with High Fever	Rubella	Jaundice
Craniofacial Anomalies	Cytomegalovirus at Birth (CMV)		
Kidney Disorders	Chemotherapy	Ototoxicity	Mastoiditis
Mastoid Surgery	Heart Attack	Otosclerosis	Menieres
Stroke	Bell's Palsy	Cholesteatoma	Diabetes

21. Please list any medications you are now taking._____
_____
_____

22. Please list any allergies to medications that you have._____
_____

Patient Record of Disclosure

In general the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). With the right to restrict it's disclosure to family, friends, etc. The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondences to the individual's office instead of the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER
ANSWER ALL THAT APPLY

Yes___ No___ May we call your home telephone? Phone #_____
Yes___ No___ May we call your cell Phone? Phone #_____
Yes___ No___ May we leave a message with detailed information on your answering machine?

Yes___ No___ May we leave message with call back number only?
Yes___ No___ May we leave a message with family?
Yes___ No___ May we contact you at work? Work #_____
Yes___ No___ May we leave a message with detailed information?
Yes___ No___ May we leave a message with call back number only?
Yes___ No___ May we email you? Email address_____

Written Communication:
Yes___ No___ May we send you a fax? Fax #_____
Yes___ No___ May we mail information to your home address on file?

You may disclose my PHI to the person or persons listed below:

_____ relationship _____

_____ relationship _____

Do not disclose my PHI for the following medical conditions:

_____ _____

_____ _____

Patient's Name **Date**

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to the use or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided on the "Accounting of Disclosures" if completed properly, will be constituted an adequate record. ***Note*** Uses and disclosures for TPO may be permitted without prior consent in an emergency.

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.
This notice takes effect on April 14, 2003 and remains in effect until we replace it.

Health Record Information:
The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Our Responsibilities: We are required to:
Keep your medical information private.
Give you this notice describing our legal duties, privacy practices, with respect to information we collect and maintain about you and your rights regarding your medical information, this is that notice.
Follow the terms of the notice that is now in effect.
We will not use or disclose your health information without your authorization, except as described in this notice.
It is policy of **Saline Audiology** to adhere to the Privacy Rule that retention of medical records for at least six years.
We Have the Right to:
Change our private practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.
Notice of Change to Private Practices:
1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.
Use and Disclosure of Your Medical Information
The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.
For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, audiologists, hearing aid vendors when orders are made, nurses, technicians, medical students or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.
For Payment: We may use and disclose your medical information for payment purposes to insurance companies in order to pay your claims.
For Health Care Operations: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.
Additional uses and disclosures: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.
Notification: Medical information to notify; Notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up hearing aids, hearing aid supplies, equipment, or medical information for you.
Disaster relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.
Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.
Funeral Director, Coroner, Medical Examiner: To help carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena issued by court.

Court orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a Court Order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, Fugitive, material witness, crime victim or missing person. We may share the medical information of a person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, disability, child abuse or neglect.

Victims of Abuse, Neglect or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other of other crimes.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Your Individual Rights: You have a right to:

1. Look at or get a copy of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies we will charge you a reasonable fee for each page and postage if you want copies mailed.
2. Receive a list of all the times we, or our business associates, shared your medical information for purposes other than treatment, payment, and health care operations and other specific exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information that you feel is in error. We may deny your request, if we did not create the information you want changed or for other certain reasons.
6. You may request an account of all disclosures of your medical information.

Questions & Complaints: If you believe your privacy rights have been violated, you may file a complaint with us. These complaints must be filed in writing and given to our Security Officer listed at the bottom of the page. You may also file a complaint with the Secretary of The Federal Department of Health & Human Services. We will not retaliate in any way for you filing a complaint.

Contact person:

Regina Burks		Regina Burks
810 N. East Street	or	110 Este Way Ste. 2
Benton, AR 72015		Hot Springs Village, AR 71909
501-778-3868		501-922-0053

Privacy Practices Acknowledgement

Saline Audiology Associates
810 N. East Street
Benton, AR 72015

Saline Audiology Associates
101 Este Way Ste. 2
Hot Springs Village, Ar. 71909

Contact Person: Regina Burks, Office Manager 501-778-3868 or 501-922-0053

Acknowledgement Form

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices.

Patient Name: _____ Date of Birth:_____

Signed:_____ Date:_____

Print Name:_____ Telephone:_____

If not signed by the patient, please indicate.
Relationship:
_____ parent or guardian of minor patient
_____ guardian or conservator of an incompetent patient
_____ beneficiary or personal representative of deceased patient

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For Office Use Only:

Acknowledgement refused:

Reason for
refusal:_____

_____

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