Advanced Audiology, Inc.
Hearing and Tinnitus Center
www.Advancedaudiology.com

7354 South Alton Way, Suite 201
Centennial, CO 80112

PATIENT INFORMATION SHEET

Name:______________________________ Date of Birth: ________________ Male Female

Address:___________________________ City:__________________ State: _____ Zip:__________

Home #: ______________ Cell:______________ Email: ____________________________

*(Advanced Audiology may use my email address for appointment reminders and communication) Yes No

Preferred method of contact: (*circle one*) Home Cell Email Work ____________________

Advanced Audiology, Inc. may speak to ______________ regarding my hearing matters. Relationship: __________

Emergency Contact: ______________________ Relationship:____________ Phone: __________

Referring Physician: ______________________ Primary Physician: ______________________

Employer:__________________ Occupation:______________________ Full Time Part Time

Student: Yes No Veteran: Yes No Marital Status: Single Married Widowed Partner

How did you hear about our office? *(circle one):*

Physician Patient *(Name)*:______________ Insurance Internet Directory Radio Newspaper

Reason for today's visit *(Please circle all that apply):*

Tinnitus *(ringing or head noises)* Hearing Loss Dizziness Hearing Aid(s) Other:______________

Other concerns or related history:____

INSURANCE INFORMATION

_____ Initial Here **<u>if you are the person who holds the insurance</u>** and to refer to the copy of your card taken .

Name of person who holds the insurance: ______________________

Date of Birth:____________

I understand that I am responsible for determining Insurance coverage for this visit. Advanced Audiology, Inc. may bill my insurance as a service, however, any unpaid balance is my responsibility. **<u>Many services, including but not limited to ear molds, hearing aid evaluations and hearing aids may not be covered by insurance.</u>** Payment is expected at the time of the visit. Advanced Audiology, Inc. has the right to charge me for any collection fees incurred. A late fee of $25.00 will be added to any bill not paid within sixty (60) days. Additional charges may also apply, including no-show charges if your appointment is not cancelled within 24 hours. I have read and agree to the above terms.

______________________________ ______________ __________

Patient or Responsible Party Signature Relationship to patient **Date**

* PLEASE REVIEW AND SIGN REVERSE SIDE *

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 APPLIES TO ALL OF THE RECORDS OF YOUR CARE GENERATED BY THE PRACTICE, WHETHER MADE BY THE PRACTICE OR AN ASSOCIATED FACILITY.

This notice describes our Practice's policies, which extend to: employees, staff and other personnel that work for/ with our Practice. The Practice provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

OUR THOUGHTS ABOUT YOUR PROTECTED HEALTH INFORMATION:

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create paper and electronic medical records about your health, our care for you, and the services and/or items we provide to you as our patient. We need this record to provide for your care and to comply with certain legal requirements. We are required by law to:

- make sure that the protected health information about you is kept private;
- provide you with a Notice of our Privacy Practices and your legal rights with respect to protected health information about you; and
- follow the conditions of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose protected health information that we have and share with others. Each category of uses or disclosures provides a general explanation and provides some examples of uses. Not every use or disclosure in a category is either listed or actually in place. The explanation is provided for your general information only.

Audiology Care: We use previously given medical information about you to provide you with current or prospective treatment or services. Therefore we may, and most likely will, disclose medical information about you to doctors, nurses, technicians, or medical students, or other hearing professionals who are involved in taking care of you. For example, a doctor to whom we refer you for ongoing or further care may need your medical record. We may also discuss your medical information with you to recommend possible treatment options or alternatives that may be of interest to you. We also may disclose audiological information about you to people outside the Practice who may be involved in your auditory care after you leave the Practice; this may include family members, or other personal representatives authorized by you or by a legal mandate (a guardian or other person who has been named to handle your decisions, should you become incompetent).

Appointment and Patient Recall Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for medical care with the Practice or that you are due to receive periodic care from the Practice. This contact may be by phone, in writing (postcards), e-mail, or otherwise and may involve the leaving of an e-mail, a message on an answering machine, or otherwise which could (potentially) be received or intercepted by others.

Payment: We may use and disclose medical information about you for services and procedures so they may be billed and collected from you, an insurance company, or a third party. For example, we may need to give your health care information about treatment you received at the Practice to obtain payment or reimbursement for the care. We may also tell your health plan and/or referring physician about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment, to facilitate payment of a referring physician or the like.

Required By Law: We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. You have the right to access your records. Our office will provide copies of these records at your request. If you have any questions or objections to the above privacy practice, please address them prior to signing.

________________________________ ________________

Patient/Legal Guardian Date

________________________________ ________________

Witness Date