Hearing & Balance Associates
Experience Life Hearing Every Moment

Dr. John Koonz, Au.D.
Michael E. McGrew, HIS

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HEARING EVALUATION – ADULT

PATIENT HISTORY

Full Name *(circle one):* Mr. Ms. Mrs. Dr. _____ ☐ Male ☐ Female

Date of Birth: _____ Age: _____ Social Security Number *(Optional)*:_____

Primary Care Physician: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone: (____) _____ Work Phone: (____) _____Cell Phone: (____) _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ _____

Referral Source: _____

Primary reason for this appointment: _____

What is the best way to reach you? ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ E-mail

Accompanied by: _____ Relationship: _____

Emergency Contact: _____ Phone Number: _____

Current Medications: _____

How did you hear about our practice? ☐ Physician (Dr. _____) ☐ Yellow book ☐ Radio

☐ Tallahassee Democrat ☐ Our Website ☐ Search Engine ☐ TV ☐ Other: _____

HEALTH INSURANCE INFORMATION

Primary Insurance: _____ ID #: _____

Primary Policyholder's Name: _____ Relationship to Patient: _____

Policyholder's Date of Birth: _____ Social Security #: _____

Address: _____

Secondary Insurance: _____ ID #: _____

IMPORTANT!

Note to our Medicare Patient – You will need to bring a prescription for audiologic evaluation and management from your family doctor. If you do not bring a script, you will be responsible for all charges incurred at this office visit. If you have any questions regarding obtaining a script, please contact our office.

INSURANCE AGREEMENT

DATE OF SERVICE _____

AUDIOLOGIST NOTICE

We will be happy to file your insurance for your hearing evaluation. However, if the insurance company denied payment, the patient is responsible for the balance due.

BENEFICIARY AGREEMENT

I have been notified by my audiologist that his office will file the insurance on my behalf. However, if the insurance company denies payment or it goes to my deductible, I agree to be fully responsible for payment.

AUTHORIZATION AGREEMENT

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

I authorize payment of medical benefits to the undersigned physician or supplier for services rendered.

Date: _____

Patient Signature: _____

Print Name: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Social Security #: _____ Phone #: _____

I acknowledge that **I received a copy of Hearing & Balance Associates of NW Florida's Notice of Privacy Practices**. I further acknowledge that a copy of the current notice will be posted in the reception area, the website (if applicable) and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

- This Notice informs me how Hearing & Balance Associates of NW Florida will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Hearing & Balance Associates of NW Florida may use and share my health information for other than treatment, payment, and health care operations.
- Hearing & Balance Associates of NW Florida will also use and share my health information as required/permitted by law.

_____ _____

Printed name of patient or personal representative **Date**

_____

Signature of patient or personal representative

AUTHORIZATION TO USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Social Security #: _____ Phone #: _____

I request and authorize **Hearing & Balance Associates of NW Florida** to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

☐ I consent to Hearing & Balance Associates of NW Florida releasing protected health as detailed below.

☐ I prohibit Hearing & Balance Associates of NW Florida from using and disclosing medical information to any person or entity other than required by HIPAA regulations.

My protected health information may be used or disclosed to the following:

_____

For the purpose of:

_____

If you need assistance in completing the authorization form, please contact Vivian Koonz at info@hbatallahassee.com

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Hearing & Balance Associates of NW Florida.

I understand that this authorization is in effect until the revocation section of this form is signed or until written notice of revocation is received. I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to **Hearing & Balance Associates of NW Florida.**

I authorize Hearing & Balance Associates of NW Florida's use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Hearing & Balance Associates of NW Florida cannot condition my treatment, services, etc… on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is a proof of legal guardianship.

_____ _____

Printed name of patient or personal representative **Date**

_____

Signature of patient or personal representative

EXPIRATION / REVOCATION SECTION

Expiration: This authorization will expire on **(must choose one):**

☐ One year from the date it is signed

☐ Other (insert date or event): _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.

I hereby revoke this authorization.

_____ _____

Printed name of patient or personal representative **Date**

_____

Signature of patient or personal representative

AUTHORIZATION AND RELEASE FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR MARKETING

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Social Security #: _____ Phone #: _____

I authorize **Hearing & Balance Associates of NW Florida** to use/disclose my protected health information for marketing related to audiological/health-related products or services. I understand that Hearing & Balance Associates of NW Florida or its business associates may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described.

I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

☐ I Authorize Hearing & Balance Associates of NW Florida to use and disclose medical information for any and all marketing purposes and understand that Hearing & Balance Associates of NW Florida or its business associate may receive financial remuneration in exchange for making the marketing communication for on behalf of the third party whose product or service is being described. A list of anticipated and potential persons/class of persons/organizations to whom information may be disclosed is included below.

☐ I request an Authorization form for each instance Hearing & Balance Associates of NW Florida intends to use and disclose medical information for any marketing purposes and understand that Hearing & Balance Associates of NW Florida or its business associate may receive financial remuneration in exchange for making the marketing communication or on behalf of the third party whose product or service is being described.

☐ I prohibit Hearing & Balance Associates of NW Florida from using and disclosing medical information for any marketing purposes.

A list of anticipated and/or potential persons/class of persons/organizations to whom information may be disclosed:
(Hearing & Balance Associates, Hearing Aid Manufacturers ex. Oticon & Phonak or Marketing Company)

If you need assistance in completing the authorization form, please contact Vivian Koonz at info@hbatallahassee.com.

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Hearing & Balance Associates of NW Florida.

I understand that this authorization is in effect for the term set forth below or until the revocation section of this form is signed and received. I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to **Hearing & Balance Associates of NW Florida.**
I authorize Hearing & Balance Associates of NW Florida's use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Hearing & Balance Associates of NW Florida cannot condition my treatment, services, etc… on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

_____ _____

Printed name of patient or personal representative **Date**

_____

Signature of patient or personal representative

Expiration: This authorization will expire on **(must choose one):**

☐ One year from the date it is signed
☐ Other (insert date or event): _____

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_____ _____

Signature of patient or personal representative **Date**

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Patient Name _____ Date _____

Reason for today's visit: _____

_____

_____

_____

Do you have hearing instruments? ☐ YES ☐ NO

Do you have ringing in your ears? ☐ YES ☐ NO

Do you have dizziness? ☐ YES ☐ NO

Do you have feeling of pressure or fullness in your ears? ☐ YES ☐ NO