Hearing & Balance Associates
Experience Life Hearing Every Moment

1818 Miccosukee Commons Drive, Tallahassee, FL 32308
Ph.: (850)553-4327 | fax: (850)877-3084
info@hbatallahassee.com | www.hbatallahassee.com

HEARING EVALUATION – ADULT

PATIENT HISTORY

☐ Male ☐ Female *(Please write legibly)*

Name *(circle one)* Mr. Ms. Mrs. Dr.		Date of Birth (mm/dd/yyyy)	Age
Street Name	City	State	ZIP Code
Home Phone	Work Phone	Cell Phone	
E-mail Address	Family/Primary Care Physician		
Occupation	Address		Social Sec. # *(optional)*
Referrer Type	Referral Source		
Primary reason for this appointment			
Accompanied by	Relationship		
Emergency Contact:	Relationship	Phone Number	

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed

What is the best way to reach you?

☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ E-mail

How did you hear about Hearing & Balance Associates?

☐ Physician (Dr. _____) ☐ Yellow Book ☐ Our Website ☐ Tallahassee Democrat ☐ Search Engine

☐ Television/Radio ☐ Other, Pls. specify _____

HEALTH INSURANCE INFORMATION

Primary Insurance:	ID#:	Copay:
Primary Policy holders name:	Relationship to patient:	
Policy holders date of birth:	Social Sec. #:	
Secondary Insurance:	ID#:	
Secondary Policy holders name:	Relationship to patient:	
Policy holders date of birth:	Social Sec. #:	

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.

Patient Name:	Date of Birth:
Address:	City/St/Zip:
SS#:	Phone #:

INSURANCE AGREEMENT

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.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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 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.

AUTHORIZATION TO USE AND DISCLOSURE OF HEALTH INFORMATION

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: _____

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

I authorize *Hearing & Balance Associates* to send me educational information and/or marketing materials related to office promotions, new products and services that may become available.
Only if you do NOT want to receive promotional information such as newsletters, flyers etc. initial here. _____
We are a training facility; therefore, at times patient visits may be videotaped or recorded for training purposes.
Only if you do NOT wish to be videotaped or recorded please initial here. _____

_____
PRINTED NAME of patient or personal representative

_____ _____
SIGNATURE of patient or personal representative **Date**

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HEALTH/MEDICAL HISTORY

Patient Name:	Date of Birth:
Address:	City/St/Zip:
SS#:	Phone #:

Please list all current medications or attach a list: _____

_____

_____

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 pressure or fullness in your ears?	☐ YES	☐ NO

Please indicate all the situations where you have been exposed to loud noises:

☐ Work ☐ Home ☐ Hobbies ☐ Shooting guns ☐ Loud music ☐ Military Service

☐ OTHER, Pls. specify _____

Please check any of the following situations where you notice hearing difficulty:

☐ Television/Movies ☐ Place of Worship ☐ At a table with 4-6 people ☐ In noisy Restaurant

Have you had any of the following? Please circle all that applies.

☐ Ear Pain ☐ Infections ☐ Drainage ☐ Ears Popping ☐ Ear Surgery ☐ Ear Tubes

☐ Arthritis ☐ Trauma (head/ear) ☐ Memory Loss ☐ Alzheimer's or Dementia ☐ Diabetes

☐ Autoimmune disease (e.g. HIV or lupus)

Any questions or comments? _____

_____

_____