CONFIDENTIAL CLIENT INFORMATION

Name:_____ Date of Birth: _____

Address:_____

City:_____ State:_____ Zip: _____

Home Phone:_____ Cell Phone:_____

Email:_____

Emergency Contact:_____ Phone Number:_____ Relationship: _____

Primary Care Physician:_____ Phone #:_____ City:_____ State:_____

If requested, do we have your permission to send your test results to your physician? ☐ YES ☐ NO

Do you have a financial Power of Attorney? ☐ YES ☐ NO ☐ Check if only for incapacitated

If yes, Name of financial Power of Attorney: _____ Phone: _____

MEDICAL AND HEARING HEALTH HISTORY

1. Do you have arthritis/rheumatoid arthritis? ☐ YES ☐ NO
2. Are you Diabetic? ☐ YES ☐ NO
3. Do you have ringing or other noises in your ears? ☐ YES ☐ NO
4. Have you received any medical or surgical treatment for your ears? ☐ YES ☐ NO
   If yes, which ear ☐ Right Ear ☐ Left Ear ☐ Both
   If yes, Date: _____ Explain: _____
5. Have you ever had your hearing tested? ☐ YES ☐ NO
   If yes, when: _____ By whom: _____
6. Are you a current hearing aid wearer? ☐ YES ☐ NO

ABOUT YOUR EARS

- Visible deformity of the ear? ☐ YES ☐ NO
- Sudden or rapid hearing loss in the last 90 days? ☐ YES ☐ NO
- Have you experienced any acute or chronic dizziness? ☐ YES ☐ NO
- Have you experienced any pain or discomfort in your ears? ☐ YES ☐ NO
- Drainage from either ear in the last 90 days? ☐ YES ☐ NO
- What ear do you hear better out of? ☐ Right ☐ Left ☐ Same/Not Sure
- Are you on a blood thinner or an aspirin regimen? ☐ YES ☐ NO

OFFICE USE ONLY: _____

HIPAA CONSENT

- I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.
- I have been informed that I may review the practice's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.
- I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.
- I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restrictions, they must follow the restriction(s).
- I understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.
- If I would like a copy of the hearing test results, I understand that there may be a cost.

Billing Authorization

I understand and agree that I am responsible for the payment of all charges incurred as a result of this or any subsequent office visit(s). I also understand and agree to accept responsibility for payment of any and all claims should my insurance carrier deny all or part of a claim.

I understand and agree that all insurance deductibles and any incurred expenses not covered by the insured's health carrier must be paid for at the time of services.

I hereby authorize payment directly to Johnson's Hearing Centers, for any services rendered to me by Johnson's Hearing Centers or any of its authorized agents.

I authorize the release of all medical information to the insured's health insurance carrier that is:

1.) acquired in the course of my examination or treatment and
2.) which may have a bearing on the benefits payable under this or any other plan that provides benefits or services.

I authorize Johnson's Hearing Centers or any of its authorized agents to assist me in obtaining payment from my health insurance companies.

I authorize a copy of this "Signature on File" form to be used in place of the original and that this copy may be used on all my insurance submissions.

Signature: _____ Date: _____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE