ARIZONA HEARING CENTER

Date: _____

PATIENT INFORMATION FORM

Patient Name _____ DOB: _____

First MI Last

Name of Responsible Party (if minor) _____

Home Phone # _____ Cell Phone # _____

Work Phone # _____ Patient's SSN: _____ Sex:_____

Email Address: _____

Mailing Address: _____

Street City State Zip Code

Age: _____ Occupation: _____

Marital Status: Married Single Widowed Divorced Long-Term Commitment

Spouse Name: _____

Emergency Contact: _____ Phone # _____

Relation to Patient: _____

Primary Care Physician: _____ Phone # _____

How did you hear about us? (Select)

Mail Newspaper Ad Promotional Call Radio Insurance

Sponsored Event Senior Health Fair Website Employer

Family/Friend _____

Referred by Physician _____

Other _____

Reason for Appointment

_____

_____

_____

PATIENT INFORMATION FORM

To provide you with the highest level of service, please rate your experience of the following areas:

Location and Accessibility	Excellent	Average	Poor
Adequate Parking	Excellent	Average	Poor
Convenience of Appointment Times	Excellent	Average	Poor
Friendly Greeting	Excellent	Average	Poor
Clean and Welcoming Environment.	Excellent	Average	Poor

What can we do to make your next visit more comfortable?

_____

_____

_____

INSURANCE INFORMATION

Please give your insurance information to our front office staff so we can make a copy for our records.

Please read carefully and sign below:

I give permission to Arizona Hearing Center to release information, verbal and written (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.

I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.

I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge and hereby give the Arizona Hearing Center permission to treat my concerns.

I have read and understand all of the above information.

_____

Patient Signature Date

_____

Signature of Parent or Guardian Date

Name: _____ DOB: _____ Date: _____

Do you have hearing aid/s? Yes☐ No☐ How old is/are your hearing aid/s? _____

Do you wear your hearing aid/s daily? Yes☐ No☐ How many hours? _____

Who services your hearing aid/s? _____

Are you satisfied with your current hearing aid/s? Yes☐ No☐

The purpose of this scale is to identify the problems your hearing loss may be causing you. Check 'Yes', 'Sometimes', or 'No' for each question. Do not skip any questions. If you use a hearing aid, please answer the way you hear with a hearing aid.

Does a hearing problem cause you to feel frustrated when speaking with family, friends, and/or coworkers?	Yes	Sometimes	No
Do you struggle to hear in groups or when background noise is present?	Yes	Sometimes	No
Does a hearing problem cause you to avoid activities you normally attend?	Yes	Sometimes	No
Does a hearing problem cause you to use the phone less often?	Yes	Sometimes	No
Do you have difficulty hearing the television or radio?	Yes	Sometimes	No
Does a hearing problem cause you to feel isolated?	Yes	Sometimes	No

Other Difficulties Pertaining to Your Hearing?_____

_____

_____

For Office Use

Notes:_____

_____

_____

_____

ARIZONA HEARING CENTER, LLC

NOTICE OF PRIVACY PRACTICES:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE READ CAREFULLY.

USE AND DISCLOSURES:

Treatment: Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, results of laboratory tests and procedures will be available in your medical records to all healthcare professionals who may provide treatment to you or who may be consulted by staff members.

Payment: We may use and disclose health information so that we or others may bill and receive payment from you, an insurance company and/or a third party for the treatment and services you received. For example, your health plan may request and receive information on dates of service provided and the medical condition being treated.

Out of Pocket Payments: If you paid out of pocket (or in other words, you have requested that we not bill your health insurance plan) in full for a specific item or service, you have the right to ask in writing that your protected health information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations. We will honor that request.

Healthcare Operations: Your health information may be used as necessary to support the day to day activities and management of Arizona Hearing Center. For example, information on the services you received may be used to support budgeting and financial reporting as well as activities to promote compliance and promote quality care within the practice.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For instance, we are required to report certain communicable diseases to the State's Public Health Department.

Other Uses and Disclosures Require your Authorization: Disclosure of your health information for use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information: Appointment reminders; your health information may be used by our staff to contact your primary residence regarding future appointments or surgical procedures.

Marketing and Fundraising: The practice does not and will not sell or provide any patient information for the use or promotion of any healthcare company or fundraising activity.

Individual Rights: You have certain rights under the Federal Privacy Policy. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical conditions.
- The right to inspect and obtain a copy of your medical record.
- The right to be notified of a breach of any of your unsecured protected health information.
- The right to receive a printed copy of this notice.

Arizona Hearing Center Duties: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in Federal and State laws and regulations. Upon request, we will provide you with the most recently revised notice at any time. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information: you may generally inspect or receive a copy of the protected information we maintain. As permitted by Federal regulation, we require that requests to inspect or copy protected health information be submitted in writing and the proper form signed by the patient or legal representative. You may obtain a form to request access to your records by contacting Rosie Villegas, Privacy Officer, and Practice Administrator. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request. We further maintain the right to charge a copying fee for your records.

Complaints and Contact Person: If you would like to submit a comment or complaint about our privacy practices, you may do so by sending a letter outlining your concerns to:

Rosie Villegas, Privacy Officer
Arizona Hearing Center
2627 N 3rd Street Suite 100
Phoenix, AZ 85004

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the address above. You will not be penalized or otherwise retaliated against for filing a complaint.

Effective date: The notice is effective on or after June 11, 2018.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

Arizona Hearing Center, LLC, reserves the right to modify the privacy practices outlined in the notice.

By signing below, I am certifying that I received a copy of the Notice of Privacy Practices for Arizona Hearing Center, LLC.

_____ _____
Name of Patient (please print) DOB

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative Relationship
(if patient is a minor or unable to sign)

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the following person(s) to receive information on the status of personal health information on the above named patient verbally or written and that the following people may speak on my behalf to Arizona Hearing Center, LLC.

_____ _____ _____
Name Relationship Phone #

_____ _____ _____
Name Relationship Phone #

_____ _____ _____
Name Relationship Phone #

I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of patient or legal representative Date

_____ _____
Signature of witness (office staff only) Date

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment of alcohol and drug abuse. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Arizona Hearing Center, LLC. I understand that the revocation will not apply to information that had already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this health information is voluntary. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 165.524. If I have questions about disclosures of my health information I can contact Arizona Hearing Center, LLC.