



Rensselaer
2 Empire Drive, Suite 204
Rensselaer, NY 12214
518-283-6111

Hudson
351 Fairview Ave., Ste 350
Hudson, NY 12534
518-283-6111

Queensbury
118 Quaker Road
Queensbury, NY 12804
518-798-6428

Patient Information Form

Date _____

Name: _____ DOB: _____

Legal Guardian if Under 18: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Email Address: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Circle all that apply: Married Widowed Single Divorced Student Employed Retired

Circle one: MALE FEMALE

Primary Care Physician: _____ Phone Number: _____

ENT Physician: _____ Phone Number: _____

Who referred you to our practice: (please circle all that apply:)

- Friend Primary care Doctor ENT Physician Walk-in
- Website Health/Senior Fair Employer Phone book
- Newspaper Attended Seminar Mail Television
- Radio Other: _____ Name of Person: _____

MEDICATIONS: (if you have a list of current medications, please give to front office staff to make a copy)

General History:

Primary reason for appointment:	Hearing Loss	Tinnitus	Sound Sensitivity	Other
Secondary reason for appointment:	Hearing Loss	Tinnitus	Sound Sensitivity	Other

Patient Signature: _____

Date: _____

Case History Form

Name _____ Age _____ DOB _____

Referred by: _____ Today's Date: _____

1. How would you best describe your hearing?

- | | |
|--|--|
| <input type="radio"/> Hearing is fine with no concerns | <input type="radio"/> Able to hear but not clearly |
| <input type="radio"/> Difficulty hearing in noisy environments | <input type="radio"/> Difficulty hearing from a distance |
| <input type="radio"/> Difficulty hearing in group situations | <input type="radio"/> Unable to hear |

2. Do you feel that your hearing is better in one ear? YES NO

If YES, which ear is better? Right Left

3. Have you previously had a diagnostic hearing test? YES NO

If YES, how long ago? _____ Results? _____

4. Have hearing aids ever been recommended? YES NO

Do you currently wear hearing aids? YES NO

How long have you used hearing aids? _____ Age of your current aids? _____

Any concerns with your current aids? _____

5. Do you ever experience tinnitus? YES NO

Is it bothersome? YES NO

Which ear? Right Left

6. Are you overly sensitive to sound? YES NO

Is it bothersome? YES NO

What type of sounds? _____

7. Do you have a history of ear infections? YES NO

8. Have you ever had ear surgery? YES NO

9. Is there a family history of hearing loss? YES NO

10. Have you ever been exposed to loud noise, recently or in the past?

- | | | |
|---|--|---------------------------------------|
| <input type="radio"/> Firearms | <input type="radio"/> Factory work | <input type="radio"/> Explosions |
| <input type="radio"/> Music | <input type="radio"/> Farm equipment | <input type="radio"/> Power tools |
| <input type="radio"/> Motorcycles/Recreational Vehicles | <input type="radio"/> Military equipment | <input type="radio"/> Heavy equipment |

Please check (✓) if you have **experienced** any of the following:

- | | | |
|--|--|---|
| <input type="radio"/> Excessive earwax | <input type="radio"/> Popping sensation of the ear | <input type="radio"/> Dizziness/Vertigo |
| <input type="radio"/> Ear pressure/fullness | <input type="radio"/> Fluid behind the eardrum | <input type="radio"/> Other _____ |
| <input type="radio"/> Fluctuating hearing loss | <input type="radio"/> Swimmer's ear | |
| <input type="radio"/> Ear drainage/bleeding | <input type="radio"/> Ear pain | |



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Please check (✓) if you have been **diagnosed** with any of the following:

- Otosclerosis
- Labyrinthitis
- Permanent hearing loss
- Bell's palsy
- Cholesteatoma
- Meniere's disease
- Ossicular dislocation/fixation
- Sudden hearing loss
- Barotrauma
- Acoustic neuroma

Medical History:

Please check (✓) if you have **experienced** any of the following:

- Heart disease
- Stroke/TIA
- High blood pressure
- Mental illness
- Depression or anxiety
- Migraines
- Meningitis
- HIV/AIDS
- Visual problems
- Chronic sinus infections
- Cancer
- Radiation
- Chemotherapy
- Long term IV antibiotics
- Loss of consciousness
- Exposure to chemicals/solvents

Using a 1 – 10 scale, how motivated are you to improve your hearing?

1 ————— 5 ————— 10

What are your expectations of today's appointment?

Would you like a copy of today's audiogram?

YES

NO

I have answered these questions accurately and to the best of my ability:

Signature of Patient/Legal Guardian

Date



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Advance Beneficiary Notice of Non-Coverage (ABN)

Patient Name: _____ **Date:** _____

NOTE: If your insurance doesn't pay for any procedures listed below, you may have to pay.

Insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance may not pay for the items listed below, but any recommended procedure will be discussed with you, along with any possible costs.

PROCEDURES	REASON INSURANCE MAY NOT PAY	Estimated Cost
1. Earmolds (if needed)	1. Insurance/Medicare may deem as a non-covered service.	1. \$125/ear
2. Cerumen Removal (if needed)	2. Insurance does not cover this procedure when performed by a licensed audiologist.	2. \$50
3. Tinnitus Retraining	3. This item may be statutorily excluded.	3. \$200
4. Routine Testing	4. Some insurances do not cover routine testing.	4. \$135
5. Hearing aid services if not under a service plan (cleaning, reprogramming, verification).	5. This is a non-covered service.	5. \$50-\$220

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive any procedures listed above.

OPTIONS: Check only one box. We cannot choose a box for you.
<input type="checkbox"/> OPTION 1. I want the procedure(s) listed above. Your insurance will be billed for an official decision on payment. I understand that if my insurance doesn't pay, I am responsible for payment, but I can appeal to my insurance company. If my insurance does pay after appeal, any payments I made will be refunded, less co-pays or deductibles.
<input type="checkbox"/> OPTION 2. I want the procedure(s) listed above, but do not bill my insurance. I am responsible for payment. I cannot appeal if my insurance is not billed.
<input type="checkbox"/> OPTION 3. I don't want any procedure(s) that may be recommended from the list above.

Additional Information: Any services we recommend that may have an out-of-pocket expense, we will discuss with you first and obtain confirmation before proceeding. Signing below means that you have received and understand this notice. You may also receive a copy.

Signature: _____	Date: _____
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Policy Statements

Privacy Policy: I understand that Audiologic Solutions Privacy Policy (HIPAA) is available to me and that I may have a copy.

Initial: _____

Authorization For Release Of Information: I authorize the release of information to my doctor or Audiologist, and physicians involved in my care, as well as to my insurance company to process any medical claims.

Initial: _____

Consent: I authorize Audiologic Solutions and any qualified authorized people employed by them to perform and/or initiate medical or diagnostic evaluation, treatment, related services or agreed upon products on my behalf.

Initial: _____

Communication: I understand that as part of my hearing healthcare, Audiologic Solutions will need to contact me to remind me of an appointment, provide test results, give instructions, or provide other information. I have indicated my preferred method of contact on the intake form.

Initial: _____

Photo ID: Due to government regulations regarding insurance fraud and mistaken identity, patients and/or guardians may be asked for a driver's license or other form of photo identification.

Initial: _____

My protected health information may be disclosed to the following (i.e. family):

My signature below acknowledges that I understand and have agreed to the above listed policies:

Signature of Patient/Legal Guardian

Date