Ahlberg Audiology
& Hearing Aid Services
"Your hearing is our priority"

4220 N. Ocoee ST NE, Suite 102
Cleveland, TN 37312
Phone/Fax (423) 641-0956
ahlbergaudiology.com

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Dear Valued Patient,

We look forward to your upcoming appointment on _____.

We have enclosed paperwork to be filled out and brought in on the day of your appointment.

I am (choose one):

_____ A New Patient.

_____Updating my paperwork as a returning patient.

_____ Reminder: If you are needing a hearing test and you have **Medicare** (red, white and blue card) as your primary insurance, it is required to have a referral from your primary care doctor sent to us PRIOR to your appointment in order for us to bill your insurance for the hearing test. Please have your doctor's office fax the referral for the "hearing evaluation" to **423-641-0955**. (*Note: A re-test of your hearing will be performed if more than a year has passed since your last test.)*

As a courtesy, we file claims to your insurance company. If you are unsure what your insurance benefits are, we are more than happy to check benefits on your co-insurance or deductibles with at least a week's notice with provided insurance information.

If you need to reschedule, we ask that you please call **24** hours of your appointment, so that we may offer that time slot to someone else. A $50 No Show Appointment Fee will be your responsibility if a 24 hour notice is not given.

During this time of COVID 19, we are following safety guidelines. A mask will need to be worn to your visit. Please call our office when you arrive in our parking lot and someone will be out to greet you.

Thank you for choosing our office to help you with your hearing concerns!

The Staff of Ahlberg Audiology

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Patient Application - Please Print

Patient Information:

Last Name:	First Name:	MI:	Nickname:	
Mailing Address:			City/State/Zip:	
Home Phone:	Cell Phone:	Work Phone:		
Email Address:		May we contact you by mail? ? Yes ? No	Email? ? Yes ? No	
Birthdate:		Social Security Number:		
Gender: ? Male ? Female	Marital Status: ? Single ? Married ? Divorced ? Widowed		Retired? ? Yes ? No	
Primary Care Physician:			Physician's Phone Number:	
How did you hear about Ahlberg Audiology? ? Physician ? Newspaper ? Website ? Mailer ? Friend ? Referral ? Other				

Employer:			Employer's Phone Number:
Spouse's Name (Parent if under 18):			Phone Number:
Primary Insurance:		Policy Holder's Name (if not patient)/DOB	
Secondary Insurance:		Policy Holder's Name (if not patient)/DOB	
Emergency Contact:	Relation:	Phone Number:	
What problems are you currently experiencing?			

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Patient Application – Please Print

New Patient Package Notifications and Releases

We want to welcome you to our practice, and ensure that your experience with every aspect of our service meets or exceeds your expectations. If you have any questions, concerns, suggestions for improvement in our services, or any comments, please do not hesitate to speak with any of our staff or audiologists. Included are several notices that outline certain responsibilities. Please read and sign.

General Consent for Treatment

We look forward to treating you as a patient. However, we need your permission for our audiologists to examine you, provide treatments, and perform diagnostic studies as necessary. If more invasive procedures are deemed necessary, such as wax removal or earmold impressions, the risks and benefits of those invasive treatments will be explained to you.

I give general consent to be treated by Ahlberg Audiology and Hearing Aid Services Staff

Signature_____ Patient or Guarantor/Date

Financial Policy/Assignment of Benefits

As a courtesy to our patients, the practice will accept assignment for some commercial insurance programs and Medicare. We will file your primary insurance claim for you. Once the primary insurance has paid, we will also file your secondary insurance, if you have provided us with that information. However, insurance is a contract between you and your insurance company. Therefore, we ask that you acknowledge your responsibility for the payment for our services. If the insurance denies coverage, disallows a service, or otherwise does not pay the claim, you are still responsible for the fees. In addition, if the fees for our services are not paid, we may turn the account over to a collection agency. If an account is turned over for collection, their fees, attorney's fees, and court cost will be added to the account balance. Also, your insurance company may ask us to provide information concerning your treatment before they will pay for the services.

I acknowledge responsibility for payment of fees for services by the practice and authorized the practice to release any medical information, if necessary, to my insurance company.

Signature_____ Patient or Guarantor/Date

Testimonials

We are very grateful for your feedback. Your signature below indicates that, should you choose to submit a review of our services, you release Ahlberg Audiology and Hearing Aid Services and its agents or employees—including any firm publishing and/or distributing the finished product, whether on paper or via electronic media—from any liability that may occur in the publication or distribution of your name, likeness, written review, and/or video testimonial.

I am 18 years of age or older and have read this release before signing below, fully understanding the contents, meaning, and impact of this release. I have not been paid in any way, and will request no compensation for the use of my name, likeness, written review, or video testimonial in the future.

Signature_____ Patient or Guarantor/Date

CONSENT TO COMPLY WITH THE FEDERAL HIPAA ACT

(For a copy of our HIPAA Privacy Policy, please ask a staff member.)

Patient Name: _____ Date: _____

With my consent and signature, Ahlberg Audiology may use and disclose protected health information about me or my child to:

1. Carry out treatment, payment, and healthcare operations (services).
2. Call my home or other designated locations and leave a message on voicemail in reference items (i.e., appointments, reminders, insurance items, references to clinical care or laboratory results, etc.) that will assist in the practice of medical care.
3. Mail to my home or other designated addresses any item (i.e., appointments, reminders, insurance items, references to clinical care or laboratory results, etc.) that will assist in the practice of medical care.
4. Send or transmit email to any location provided by me for all of the above similar items and purchases.
5. Communicate or partner with third parties, including but not limited to insurance companies, hospitals, specialty physicians, and laboratory personnel. Ahlberg Audiology may transfer to the third party the information it requests or requires (i.e., dates of services, level of detail, origin of information, etc.)—which is a permission that I have the option to revoke by providing a written statement to the privacy officer of the practice, at a designated time and date chosen by me. I understand that my doing so could cause Ahlberg Audiology to rightfully decline further treatment for me or my child.

- I have read the right to review the Notes of Privacy Policy of Ahlberg Audiology (for a copy, please see a staff member). Ahlberg Audiology may revise its manual and procedures at any time deemed necessary, and I may request from time to time, in writing, such changes, should these changes directly relate to my care or the care of my child.
- I have the right to request that Ahlberg Audiology restrict the manner in which my or my child's health information is used or disclosed. However, Ahlberg Audiology is not required to agree with my restrictions. If Ahlberg Audiology accepts my restrictions, Ahlberg is bound by the restriction in the agreement setting forth in the restricted information until providing me, in writing, a cessation, of such agreement. However, should Ahlberg Audiology withhold approval of such restrictions, I understand that they may rightfully decline further treatment for me or my child.
- I may revoke this entire consent, in writing, at any time. If I revoke this consent form, or refuse to sign it, Ahlberg Audiology, in their sole discretion, may decline further treatment for me or my child.

I wish to be contacted in the following manner (check all that apply):

☐ **Home Phone** ☐ **Cell Phone** ☐ **Text Message** ☐ **Email** ☐ **Work Phone**

☐ **Message on answering machine** ☐ **Message left with person who answers phone**

You may disclose PHI (Protected Health Information) to the person(s) listed below:

_____

Patient Signature: _____ Date: _____

The privacy rule requires healthcare providers to take responsible steps to limit the use or disclosure of PHI to the minimum necessary to accomplish the Intended purpose. These provisions do not apply to the use or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures, information provided on the "Accounting of Disclosures", which, if completed properly, will be serve as an adequate record. *Note: Uses and disclosures of information may be permitted without prior consent in the case of an emergency.

QUICK PATIENT PROFILE

1. What brought you into the office today? _____

2. Please select the following boxes that apply to your current hearing abilities in various environments.
   Select one: ☐ With Hearing Aids ☐ Without Hearing Aids

Listening Environments	How well do you currently hear in this environment?			How frequently are you in this environment?			3 Most-Difficult Environments:
One-on-one conversations	Well ☐	Fair ☐	Poor ☐	Often ☐	Sometimes ☐	Rarely ☐	☐
Small Groups (4-6 people)	Well ☐	Fair ☐	Poor ☐	Often ☐	Sometimes ☐	Rarely ☐	☐
Large Groups	Well ☐	Fair ☐	Poor ☐	Often ☐	Sometimes ☐	Rarely ☐	☐
At the workplace	Well ☐	Fair ☐	Poor ☐	Often ☐	Sometimes ☐	Rarely ☐	☐
Watching television	Well ☐	Fair ☐	Poor ☐	Often ☐	Sometimes ☐	Rarely ☐	☐
During religious services	Well ☐	Fair ☐	Poor ☐	Often ☐	Sometimes ☐	Rarely ☐	☐
Meetings/Lectures	Well ☐	Fair ☐	Poor ☐	Often ☐	Sometimes ☐	Rarely ☐	☐

3. What are your experiences with hearing aids? Check all that apply:
   - ☐ I have never visited a Hearing Healthcare Professional to inquire about hearing aids.
   - ☐ I have been to another Hearing Healthcare Professional to gather information regarding my hearing difficulties but have not tried or purchased.
   - ☐ I have hearing aid(s) but wear them only occasionally, or not at all -- ☐ right ear, ☐ left ear.

4. Circle one: I am (not / somewhat / extremely) motivated to do something about my hearing loss.

5. Are you:
   - ☐ Prefer hearing aids with the latest technology (wireless streaming, noise reduction, etc.)
   - ☐ Prefer to give up such features for hearing aids at a lower price

6. What type/model of phone do you have? _____

MEDICAL HISTORY

Check All That Apply:

- ☐ Hearing Loss – Gradual
- ☐ Hearing Loss – Sudden
- ☐ Worn Hearing Aids
- ☐ Family History of Hearing Loss
- ☐ Past Ear Surgery
- ☐ Taking Blood Thinners
- ☐ History of Depression
- ☐ History of Cancer
- ☐ Tinnitus
- ☐ Dizziness
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Stroke
- ☐ Fallen in the past 6 months
- ☐ Fallen in the past year
- ☐ Chronic Ear Pain/Drainage
- ☐ Vision Problems
- ☐ Past Head Injury
- ☐ Meningitis
- ☐ Measles
- ☐ Noise Exposure
- ☐ Current Tobacco User
- ☐ Other(s):_____

_____

_____

_____

Please List All Medications You Are Currently Taking:

(If you already have a list, we will be happy to make a copy instead)

_____

_____

_____