



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

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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. **Our office hours are Monday through Thursday, 8am-4pm, Friday 8am-12pm.**

**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



Patient Application - Please Print

PATIENT INFORMATION

DATE: \_\_\_\_\_

Full Name: \_\_\_\_\_
Last First M.I. Nickname

Address: \_\_\_\_\_
Street Address Apartment/Unit #

City State ZIP Code

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_

May we contact you by mail? [ ] YES [ ] NO May we contact you by email? [ ] YES [ ] NO

Birthdate: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Gender: [ ] Male [ ] Female

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed Retired: [ ] YES [ ] NO

How did you hear about Ahlberg Audiology?
[ ] Physician [ ] Newspaper [ ] Website [ ] Facebook [ ] Online Search [ ] Mailer [ ] Friend [ ] Referral [ ] Other: \_\_\_\_\_

Do you have any friends or family who are patients at our office? [ ] YES [ ] NO IF YES, NAME \_\_\_\_\_

Employer: \_\_\_\_\_ Employer's Phone: \_\_\_\_\_

Spouse's Name (Parent, if Under 18): \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care/Referring Physician: \_\_\_\_\_

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? \_\_\_\_\_

**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* \_\_\_\_\_

\_\_\_\_\_ *Opt out of emails from our office other than testimonial (Your email address will never be sold or shared outside this office.)*

# **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.

## 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)

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## Hearing Health Assessment

### ***New Patients***

In our experience, we have found many people describe hearing loss as the perception of Sound Voids which is a moment lacking clarity in hearing or understanding. This affects normal and daily routines and the lives of those around. Please answer the following situational questions to help us better understand your listening lifestyle and how we can help improve you and your loved one's quality of life.

	Frequently	Sometimes	Rarely
When using the telephone, how often to you experience Sound Voids?			
When watching television, how often do you experience Sound Voids?			
When in restaurants, how often are you experiencing Sound Voids?			
How often do Sound Voids cause you to ask others to repeat themselves?			
When in background noise, how often do you experience Sound Voids?			
When listening to women or children, how often do you experience Sound Voids?			
How often do Sound Voids cause you to hear but misunderstand?			
How often do Sound Voids make you feel as though people are mumbling?			
How often are Sound Voids causing you to feel stressed or tired after listening for long periods of time?			

***Please circle the top 3 listening situations you would like to hear better***

Driving      Outdoors      Telephone      Family      Religious  
 Television      Meetings      Restaurant      Travel      Music  
 Social      Other \_\_\_\_\_

***Please select your current lifestyle and your desired lifestyle***

Active Lifestyle (Frequent Background Noise)       Current       Desired  
 Casual Lifestyle (Occasional Background Noise)       Current       Desired  
 Quiet Lifestyle (Limited Background Noise)       Current       Desired  
 Very Quiet Lifestyle (Rare Background Noise)       Current       Desired

Do you have a cell phone?  Y     N

If so, what type of phone do you have? \_\_\_\_\_

**IMPORTANT NOTE:**

**\*If you have an Apple phone and wish to have an App installed to adjust your hearing devices please have your Apple ID and Apple ID password available at the fitting appointment so that we can download the App from the App Store.**

When was your last hearing exam? \_\_\_\_\_ Where? \_\_\_\_\_

What were the recommendations? \_\_\_\_\_

Have you ever used a hearing device?  Y  N If yes what type? \_\_\_\_\_

What brand and technology level were the instruments? \_\_\_\_\_

If not, sure what was price of instruments? \_\_\_\_\_

Have you ever had ear surgery?  Y  N If yes what type and who performed? \_\_\_\_\_

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