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

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: _____ Phone: _____

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)

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 select 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 yes, what type of phone do you have? _____

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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& Hearing Aid Services
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ahlbergaudiology.com

Tiffany C. Ahlberg, Au.D, CCC-A
Lynda J. Klee, Au.D, CCC-A
Ellyn E. Grider, B.S., Audiology Resident

ATTENTION

Ahlberg Audiology wants to give each patient excellent care and service. To do so, it is necessary for us to make appointments in order to see our patients as efficiently as possible. No shows and late cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No shows and late cancellations delay the delivery of healthcare and hearing aid assistance to patients.

A ”no show” is missing a scheduled appointment. A “late cancellation” is cancelling an appointment without calling us to cancel within 24 hours of an office appointment. Our policy is that if you do not confirm your appointment via text, call or email at least 24 hours in advance, the appointment spot will be filled with another patient. If you show for this appointment without confirming, we will need to reschedule your appointment. If you “no show” for an appointment twice your appointment can not be rescheduled.

To cancel or reschedule an appointment, please call our office (423) 641-0956 at least 24 or more hours to your appointment. We understand that situations such as medical emergencies occasionally arise. Just give us a call as soon as you are aware of the need to reschedule.

We appreciate your trust in Ahlberg Audiology for your hearing healthcare needs.

_____ _____

Signature Date