4220 Ocoee Street N. Suite 102
Cleveland, TN 37312
Phone: 423-641-0956
Fax: 423-641-0955
www.ahlbergaudiology.com

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

605 Congress Pkwy S
Athens, TN 37303
Phone: 423-212-9110
Fax: 423-641-0955
www.ahlbergaudiology.com

PATIENT INFORMATION (please print) **Today's Date: _____**

Patient Name _____ (preferred name) _____

Phone # _____ Mobile? Y/N Phone # _____ Mobile? Y/N

Birth Date _____/_____/_____ Email _____

Address _____ City _____ State ___ Zip _____

Gender: M / F / Other Social Security # (VA only) _____-____-_____ Marital Status: Single / Married

Spouse's Name _____ Phone # _____

Parent's Name (if under 18) _____ Phone # _____

Primary Care Physician _____ Phone # _____

Physician Office _____ Retired? Y / N Employer _____

How did you hear about us? _____

Do you have family or friends who are our patients? Who? _____

What problems are you experiencing? _____

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 you're not sure, what price were they? _____

Have you ever had ear surgery? Y / N If yes, what type? _____

Who performed the surgery? _____

Check All That Apply:

- ☐ Hearing Loss – Gradual / Sudden
- ☐ Family History of Hearing Loss
- ☐ Taking Blood Thinners
- ☐ History of Depression
- ☐ History of Cancer
- ☐ Tinnitus
- ☐ Dizziness
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Stroke
- ☐ Fallen in the past 6 months
- ☐ Chronic Ear Pain/Drainage
- ☐ Vision Problems
- ☐ Past Head Injury
- ☐ Meningitis
- ☐ Measles
- ☐ Noise Exposure
- ☐ Other_____

Ahlberg Audiology Consent and Policies

Welcome to our practice! We hope our service exceeds your expectations! Please review and sign the following:

General Consent for Treatment & Cerumen/Foreign Body Removal Consent

I consent to be treated by Ahlberg Audiology and authorize the necessary exams, treatments, and procedures, including wax or foreign body removal or earmold impressions, with explanation of risks and benefits if applicable.

The process of wax removal can involve discomfort, bleeding, hearing loss, and tinnitus. Certain risk factors may make it more likely for you to incur complications such as bleeding and irritation, and may occur even if you have no risk factors, but these complications are not life threatening. If you decide you do not want to have your wax removed at any time, you may stop the procedure.
By signing this form, you agree to release Ahlberg Audiology, its owners, officers, directors, employees, and representatives from any complications arising from the removal of ear wax or foreign bodies from your ear canal as explained above.

Medicare and most private insurances consider Cerumen Removal a non-covered service. I understand I will be financially responsible for this service.
I have been informed of my condition and voluntarily give my consents for cerumen or foreign body removal.

Signature_____ Patient or Guarantor/Date_____

Financial Policy/Assignment of Benefits

I acknowledge responsibility for payment of services. The practice will file insurance claims, but if denied, I remain liable. Unpaid fees may result in collection actions.

I understand Ahlberg Audiology will attempt to verify my coverage prior to my visit, but it is my responsibility to be fully aware of my insurance policy, including coverage, exclusions, limitations, and authorization requirements. However, if my coverage is not in effect, preauthorization or referrals are missing, or services are denied at the time of my visit, **I will be financially responsible for any excess charges, deductibles, co-pays, or uncovered services** and that **full payment is due at the time of visit or when you receive an invoice.**

I understand that Ahlberg Audiology will assist in submitting my claim to my insurance carrier.
I authorize my insurance company to send payment of medical benefits directly to Ahlberg Audiology and permit my provider to release necessary medical information to my insurance company.

Signature_____ Patient or Guarantor/Date_____

Testimonials

We appreciate your feedback to help us improve our services. By signing below, you give Ahlberg Audiology permission to use your name, photo, written review, or video testimonial in any media. You confirm that you are 18 or older, haven't be compensated, and won't seek compensation in the future.

Signature_____ Patient or Guarantor/Date_____

(Note: 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: _____

By signing, I consent to Ahlberg Audiology using and disclosing my protected health information (PHI) for the following purposes:

1. To carry out treatment, payment, and healthcare operations.
2. To leave voicemail messages or send mail/emails related to appointments, reminders, or clinical care.
3. To communicate with third parties (e.g., insurance companies, specialists, labs) as necessary for my care.
4. I understand I can revoke this consent in writing, which may result in Ahlberg Audiology declining further treatment.

I acknowledge:

- I have the right to review Ahlberg Audiology's Privacy Policy (available upon request). The practice may update its policies, and I can request written changes if they relate to my or my child's care.
- I can request restrictions on how my or my child's health information is used or shared, but Ahlberg Audiology is not required to agree. If they do accept my restrictions, they will follow them until I request changes in writing. If restrictions are not accepted, Ahlberg Audiology may refuse further treatment.
- I can revoke this consent in writing at any time, and if I do, Ahlberg Audiology may choose to stop treating me or my child.

Contact Preference (check all that apply):

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

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

I agree that Ahlberg Audiology may disclose PHI (Protected Health Information) to the person(s) listed below:

Name: _____ Phone# _____

Name: _____ Phone# _____

Emergency contact: _____ Phone # _____

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.

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Appointment Policy

At Ahlberg Audiology, we aim to provide excellent care to all our patients. To do this, we need to manage appointments efficiently. Unconfirmed appointments, No-shows, Late-shows, and Late Cancellations disrupt the care we provide to other patients.

- A **no-show** is when you miss an appointment without notifying us.
- A **late-show** is when you show up over 15 minutes late to your appointment.
- A **late cancellation** is when you cancel less than 24 hours before your appointment.

If you do not confirm your appointment (via text, email, or call) 24 hours in advance, your appointment may be given to another patient.

If you arrive without confirming, your appointment may be forfeit and we'll need to reschedule.

If you show up over 15 minutes late, your appointment may be forfeit and we'll need to reschedule.

After two no-shows or late cancellations, you may be charged a fee of $65 which must be prepaid before scheduling another appointment.

To cancel or reschedule, contact our Cleveland office at (423) 641-0956 or our Athens office at (423) 212-9110 or office@ahlbergaudiology.com at least 24 hours before your appointment. We understand emergencies happen – just let us know as soon as you can.

Thank you for trusting Ahlberg Audiology with your hearing care.

_____ _____

Signature Date

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

Advance Beneficiary Notice of Noncoverage (ABN)

Ahlberg Audiology and Hearing Aid Services LLC
4220 Ocoee ST N, Suite 102
Cleveland, TN 37312
Phone: (423) 641-0956
Fax: (423) 641-0955
ahlbergaudiology.com

A. Notifier:Ahlberg Audiology and Hearing Aid Services LLC

B. Patient Name:

NOTE: If Medicare doesn't pay for **D.** (See below), you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** (See below).

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Hearing Aids, Fittings, or Cerumen removal	Depends on the type and medical necessity	

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 the **D.** (listed above).

Note: If you choose Option 1 or 2, we may help you use any other insurance that you may have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one option. We cannot choose an option for you.

__ **OPTION 1.** I want the **D.** (listed above). You may ask to be paid now, but **I** also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). **I** understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by the following the directions on the MSN. If Medicare does pay, you will refund any payments **I** made to you, less co-pays or deductibles.

__ **OPTION 2.** I want the **D.** (listed above), but do not bill Medicare. You may ask to be paid now as **I** am responsible for payment. **I cannot appeal if Medicare is not billed.**

__ **OPTION 3.** I don't want the **D.** (listed above). I understand with this choice **I** am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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