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Cleveland, TN 37312
Phone: 423-641-0956
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www.ahlbergaudiology.com



605 Congress Pkwy S
Athens, TN 37303
Phone: 423-212-9110
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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:

- | | | |
|--|--|---|
| <input type="checkbox"/> Hearing Loss – Gradual / Sudden | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Family History of Hearing Loss | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Past Head Injury |
| <input type="checkbox"/> Taking Blood Thinners | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> History of Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles |
| <input type="checkbox"/> History of Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Noise Exposure |
| <input type="checkbox"/> Tinnitus | <input type="checkbox"/> Fallen in the past 6 months | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Chronic Ear Pain/Drainage | |

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. Ahlberg Audiology will assist in submitting my claim to my insurance carrier, 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 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.

I acknowledge that Medicare never covers hearing aids or cerumen (wax) removals.

I also understand that once my service and/or manufacturer warranties expire, office fees will apply and I am responsible to pay for those at the time of my visit.

Signature _____ **(Patient or Guarantor)** **Date** _____

Testimonials (optional)

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** _____

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CONSENT TO COMPLY WITH THE FEDERAL HIPAA ACT

(For a copy of the complete HIPAA Notice of Privacy Practices, please ask a staff member.)

Patient Name: (please print) _____ **Date of Birth:** ____/____/____

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 restrict or revoke this consent in writing, which may result in Ahlberg Audiology declining further treatment.
5. I acknowledge I have the right to request a copy of Ahlberg Audiology's HIPPA Notice of Privacy Practices. The practice may update its policies, and I can request written changes if they relate to me or my child's care.

(Note: your email address will never be sold or shared outside this office. If you have questions or complaints our Privacy Officer, Donny Ahlberg, can help you.)

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:

Emergency contact: _____ **Phone #** _____

Disclose to: _____ **Phone #** _____

Disclose to: _____ **Phone #** _____

Patient Signature: _____ **Date:** _____

(or Guarantor): _____ **Relationship to patient:** _____

(Refusal to Sign Staff Initials: _____ 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 serve as an adequate record. *Note: Uses and disclosures of information may be permitted without prior consent in the case of an emergency.



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.

Patient Signature (or Guarantor)

Date

Patient Notice

To ensure the safety and well-being of all patients and staff, we want to inform you that we do not have personnel available to assist with lifting or with bathroom needs.

Patients who require physical assistance—including those with mobility limitations or disabilities—are asked to bring a caregiver or support person to help during their visit.

We are committed to providing respectful and accessible care and will do our best to accommodate all patients within these limitations.

We appreciate your understanding and cooperation.