



Audiology & Hearing Aid Center, LLC

Acknowledgment of HIPPA (Health Information of Privacy Policy Act)

Patient Name: _____

As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the U.S. Department of Health and Human Services office of Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices, or in accordance with your wishes as stated below.

I received and reviewed AHAC's Notice of Privacy Practices which describes how my medical information may be used and disclosed and explains how I can get access to this information.

I had an opportunity to raise questions regarding this policy and all of my questions have been answered: ___yes___no

The authorizations made above will remain effective until such time as I notify AHAC's office in writing, of requested changes.

This waiver authorizes Audiology and Hearing Aid Center, LLC (AHAC). to send/give my medical information as noted:

Leave a voice mail recording including my Personal Health information on my home/cell phone: ___yes___no

Leave a voice mail recording including my Personal Health information on my business phone: ___yes___no

Permit AHAC to share personal health information with other health care providers, family members and/or school personnel as necessary to carry out my care: ___yes___no

Authorized person (s) to share information with:

Audiology and Hearing Aid Center does not release any Health Protected information to any outside entity for remuneration for marketing.

Signature of Patient/Legal Guardian:

Date: _____

Patient's Date of Birth: _____

Consent for Treatment

I voluntarily give my permission to the health care providers at Audiology and Hearing Aid Center, LLC (AHAC) as they deem necessary to provide services to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from, or until I withdraw my consent in writing.

Your audiologist may decide it would be best to remove ear wax from your ear canal. Removing ear wax is something that is not without risk. Certain risk factors may make it more likely for you to incur complications such as bleeding or irritation. These complications may occur even if you have no risk factors but these complications are not life threatening. The process of wax removal can involve discomfort, slight bleeding, or tinnitus. If you decide you do not wish to have your wax removed at any time, you may decline or stop the procedure.

I understand that all information shared with the audiologists at AHAC, LLC is confidential and no information will be released without my consent. I further understand that there are specific and limited exceptions to this confidentiality which would include the following:

- A. When there is a risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
- B. When there is suspicion that a child or an elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child or elder, and to inform the proper authorities.
- C. When a valid court order is issued for medical records, AHAC, LLC is bound by law to comply with such requests.

If I have any questions regarding this consent form or about the services offered at AHAC, LLC, I may discuss them with my clinician. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by AHAC, LLC. I understand that I may stop treatment at any time.

Signature

Date

Confidential Patient History

Patient name: _____ **Date:** _____

Marital Status: Single Married Divorced Widow Domestic Partner

Current Employment: Full Time Part Time Retired Unemployed Stay at Home Student

Do you currently use tobacco? **YES NO**

If Yes, what do you smoke? Cigarettes cigars pipe smokeless other: _____

If Yes, amount/day: _____

Do you currently drink alcoholic beverages? **YES NO**

If yes, how often? Daily Weekly Monthly Occasionally Rarely

Audiologic History

Do you experience hearing loss? **YES NO** If so, which ear? **RIGHT LEFT BOTH**

If you experience hearing loss, which best describes it? **Gradual Fluctuating Sudden**

When did you first notice your hearing loss? _____

What do you think is the cause of your hearing loss? _____

Ever seen an Ear/Nose/Throat doctor? **YES NO** If Yes, When? _____ Who? _____

Ear Surgery? **YES NO** If yes, please describe: _____

Ever had hearing tested before? **YES NO** If Yes, When? _____ Who? _____

Do you currently wear hearing aids? **YES NO**

If yes, how long? _____ **RIGHT LEFT BOTH** _____

If no, have you ever tried hearing aids? **YES NO**

Please check all medical condition that apply:

- ___ **Developmental Disorders/Delays** If checked, please explain: _____
- ___ **Dizziness or Unsteadiness** If checked, is it accompanied by: Vomiting Nausea Ear Noises
- ___ **Ear Deformity** If checked, Right ear Left ear Both ears
- ___ **Ear Drainage** If checked, Right ear Left ear Both ears
- ___ **Ear Pain** If checked, Right ear Left ear Both ears
- ___ **History of Ear Infections** If checked, Right ear Left ear Both ears
- ___ **Previous Ear Surgery** If checked, Right ear Left ear Both ears
- ___ **Tinnitus/Noises in Ears** If checked, Right ear Left ear Both ears Frequency? _____
- ___ **History of Wax build up** If checked, Right ear Left ear Both ears
- ___ **Family History of Hearing Loss** If checked, who? _____
- ___ **History of Noise Exposure** If checked, Please describe: _____

Please check any of the following that you currently have or have had in the past:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Measles | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Bell 's palsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mumps | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV | <input type="checkbox"/> Neurological | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Malaria | <input type="checkbox"/> Vascular Problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Chicken Pox/Shingles | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Genetic Disorder | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Influenza | <input type="checkbox"/> High Fevers | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Other _____ | | |

Current Medications/dosages (OTC and Prescriptions): _____

Please check all that apply:

- ___ **Eye Problems/Blurred Vision** ___ **Nose, Throat, Mouth Problems**
- ___ **Neurologic Symptoms (numbness, headaches, seizures, muscle weakness)**
- ___ **Psychiatric Issues (depression, anxiety, compulsions)**
- ___ **Allergic/Immunologic Symptoms (such as hives, asthma, itching, immune deficiency)**