AUDIOLOGY ASSOCIATES OF DFW

3132 Matlock Rd #303
Arlington, TX 76015
817.472.7720

610 Uptown Blvd
#2000Cedar Hill, TX
75104 817.504.3644

Adult Patient Information

Date:_____
MM/DD/YYYY

PATIENT INFORMATION

Name:_____
Title First MI Last

Preferred name:_____

Address:_____
Street # Street Name Apt/Unit City State Zip

Date of Birth:_____ Marital Status:_____ Gender:_____
MM/DD/YYYY

Preferred phone:_____2nd phone:_____Other phone:_____

Email address:_____ Current/Previous Occupation:_____

Emergency contact name:_____Phone number:_____

Relationship to patient:_____

ALTERNATE CONTACT INFORMATION

Name:_____
Title First MI Last

Relationship:_____ Email:_____

Preferred phone:_____ Check if alternate contact is the primary contact ☐
Check if alternate contact should be used for billing ☐

Address:_____
Street # Street Name Apt/Unit City State Zip

Name:_____ Date of Birth:_____

REFERRAL INFORMATION

Primary care physician: _____Phone number:_____

Address: _____

Street # Street Name Apt/Unit City State Zip

How did you hear about us? _____

What is the reason for your visit today? _____

INSURANCE INFORMATION

*If you have a **Medicare Advantage** plan, use that for your **Primary** Insurance (not your Medicare information)*

Primary Insurance name:_____

Insurance ID number: _____

Primary Policy holder name:_____

Primary Policy holder birthdate:_____ Relationship to patient:_____

MM/DD/YYYY

Address of subscriber, if different than patient:

_____

Street # Street Name Apt/Unit City State Zip

Secondary Insurance name:_____

Insurance ID number: _____

Primary Policy holder name:_____

Primary Policy holder birthdate:_____ Relationship to patient:_____

MM/DD/YYYY

Address of subscriber, if different than patient:

_____

Street # Street Name Apt/Unit City State Zip

Name:_____ Date of Birth:_____

Do you have hearing loss? ◯ Yes ◯ No

Was hearing loss: ◯ Sudden ◯ Gradual ◯ N/A

Which ear hears better? ◯ Right ◯ Left ◯ Same

Family history of hearing loss? ◯ Yes ◯ No

Have you ever been evaluated by an ENT (ear/nose/throat) physician? ◯ Yes ◯ No

MEDICAL HISTORY

Please indicate when you have experienced the following:

	In the past 12 mons	More than 12 mons ago	Never
Dizziness	◯	◯	◯
Ear drainage	◯	◯	◯
Ear infections	◯	◯	◯
Ear pain	◯	◯	◯
Ear fullness	◯	◯	◯
Ear surgery	◯	◯	◯
Ringing/noises in ears	◯	◯	◯
Sensitivity to sounds	◯	◯	◯
Fluctuating hearing	◯	◯	◯
Exposure to loud noise	◯	◯	◯
Previous hearing test	◯	◯	◯
Wore hearing aids	◯	◯	◯

Cancer	◯	◯	◯
Diabetes	◯	◯	◯
Heart disease	◯	◯	◯
High Blood pressure	◯	◯	◯
Kidney disease	◯	◯	◯

Alzheimer's	◯	◯	◯
Dementia	◯	◯	◯
Parkinson's	◯	◯	◯
Stroke/TIA	◯	◯	◯

Name:_____ Date of Birth:_____

	In the past 12 mons	More than 12 mons ago	Never
Autoimmune disease	◯	◯	◯
Arthritis	◯	◯	◯
Bell's Palsy	◯	◯	◯
Covid-19	◯	◯	◯
Measles	◯	◯	◯
Meningitis	◯	◯	◯
Mumps	◯	◯	◯

Jaw popping/locking	◯	◯	◯
Jaw pain	◯	◯	◯
Head trauma	◯	◯	◯
Sleep apnea	◯	◯	◯
Other sleep problems	◯	◯	◯
Vision loss	◯	◯	◯

Please list (or provide list) of current medications and why they were prescribed:

_____

Any physical limitations? ◯ Yes ◯ No

If yes, describe: _____

If you are currently wearing a hearing aid or have in the past please answer the following:

Which ear aided:_____ Brand:_____ Style:_____

Age of hearing aid(s):_____ How often do you wear it:_____

Where was it purchased: _____

What would you like to improve about your current hearing aids:

_____

AUDIOLOGY ASSOCIATES OF DFW OFFICE POLICIES AND NOTICES

Consent for Services

Thank you for choosing Audiology Associates of DFW for your audiology needs. By coming to your appointment you consent to receive audiological services at our office. This consent encompasses audiology procedures including, but not limited to, diagnostic testing, and rehabilitative treatment. I understand that this consent form will be valid and remain in effect as long as I receive audiological care at Audiology Associates of DFW.

Cancellation Policy

Audiology Associates of DFW reserves the right to charge a $25 fee for failure to give 24 hours cancellation notice and late arrivals (15 minutes or more). This fee will be collected prior to rescheduling of missed/late arrival appointment.

Payment Policy

Payment in full is due at the time the services are provided. You are responsible for paying all out-of-pocket expenses, such as co-payments, co-insurance, deductibles, and the costs of non-covered services on the date the service is provided, or the item is dispensed. There will be a $40 fee for all returned checks. Audiology Associates of DFW reserves the right, following 120 days of the initial invoice date, to forward all outstanding balances to a third-party collection agency. We also reserve the right to discontinue care or service to patients who have not met their financial obligations to our office.

If utilizing insurance for your appointment:

Insurance coverage is an agreement between you and your insurance company. We, as healthcare providers, just execute that agreement for you. By asking us to submit a claim to your insurance for services and items rendered you are authorizing Audiology Associates of DFW to release your medical information to your insurance company and its utilization review.

Audiology Associates of DFW makes every effort to determine your eligibility and benefits but it is ultimately the responsibility of the patient to determine whether or not they have out of network benefits (if Audiology Associates of DFW is not a participating provider in your insurance plan), if you require prior authorization, or a referral prior to services being provided of if audiology services and/or hearing aids are covered through your plan. Audiology Associates of DFW cannot submit a claim to any insurance company if we do not have all required orders, referrals, or prior authorizations on file. They cannot be obtained after the service is provided. If you are unsure of your coverage specifics, please bring your member benefits information with you to the appointment.

Insurance companies do not cover, in full, all goods and services. While we verify coverage specifics with your insurance company as needed, please understand that these are NOT a guarantee of coverage or payment. There may be situations where your insurance company does not cover the specific goods or services you are requesting.

Notice of Privacy Practices

The Notice of Privacy Practices provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full notice. The notice is made available to all patients when filling out new patient paperwork, posted in the reception area and on our website, and that any revised Notice of Privacy Practices will be made available upon request.

Communication with Patients

Audiology Associates of DFW text (SMS) and email messaging service is designed to provide you with helpful information, reminders, and notifications via text (SMS) and email messages to communicate with you for a variety of purposes including appointment reminders, warranty expiration reminders, educational and/or marketing material, and announcements of upcoming events. No remuneration is involved in this communication.

While every effort will be made to protect the security and confidentiality of information transmitted through text (SMS) and email messages, there are inherent risks associated with all electronic communication. These risks include unauthorized access, loss of privacy, and potential breach of sensitive information. It is important to be aware that text (SMS) and email messages may not be entirely secure and could be intercepted or accessed by unintended recipients.

Participation in the text (SMS) messaging service may involve standard text messaging charges applied by your mobile service provider. Please consult your mobile service provider regarding any applicable fees or charges.

Participation in our text (SMS) and email messaging service is entirely voluntary. You have the right to refuse or withdraw your consent at any time. If you would like to opt out of text (SMS) and/or email messages, please select an option below.

Opt out of all email messages ☐ Opt out of all text messages ☐ Opt out of only educational and marketing event messages ☐

*Choosing to opt out will opt out of **all** messages (including appointment and warranty reminders) and will prevent us from sending text (SMS) or email messages for **any** reason.*

Patient Authorization of Disclosure

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means. The patient may revoke or change this authorization at any time with a written request.

Please indicate any persons with which you would like us to be able to communicate health,insurance, and/or financial information relating to your hearing health care:

Name:_____ Relationship_____ Phone# _____

Name:_____ Relationship_____ Phone#:_____

By signing below I acknowledge that I have carefully read Audiology Associates of DFW's Office Policies and Notices in full and agree and consent to the statements above.

Patient Signature: _____ **Date:**_____

AUDIOLOGY ASSOCIATES OF DFW

NOTICE OF PRIVACY PRACTICES

EFFECTIVE MARCH 01, 2020

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
You have the right to a paper copy of this Notice; you may request a copy at any time.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

We may use and disclose your health information for the following purposes without your express consent or authorization.

Treatment. We may use your health information to provide you with medical treatment. We may disclose information to doctors, nurses, technicians, medical students, or other personnel involved in your care. We also may disclose information to persons outside our organization involved in your treatment, such as other health care providers. We may use and disclose health information to discuss with you treatment options or health-related benefits or services or to provide you with promotional gifts of nominal value. We may use and disclose your health information to remind you of upcoming appointments. Unless you direct us otherwise, we may leave messages on your telephone answering machine identifying our organization and asking for you to return our call. We will not disclose any health information to any person other than you except to leave a message for you to return the call.

Payment. We may use and disclose your health information as necessary to collect payment for services we provide to you. We also may provide information to other health care providers to assist them in obtaining payment for services they provide to you.

Health Care Operations. We may use and disclose your health information for our internal operations. These uses and disclosures are necessary for our day-to-day operations and to make sure patients receive quality care. We may disclose health information about you to another health care provider or health plan with which you also have had a relationship for purposes of that provider's or plan's internal operations.

Business Associates. We provide some services through contracts or arrangements with business associates. We require our business associates to appropriately safeguard your information.

Creation of de-identified health information. We may use your health information to create de-identified health information. This means that all data items that would help identify you are removed or modified.

Uses and disclosures required by law. We will use and/or disclose your information when required by law to do so.

Disclosures for public health activities. We may disclose your health information to a government agency authorized (a) to collect data for the purpose of preventing or control disease, injury, or disability; or (b) to receive reports of child abuse or neglect. We also may disclose such information to a person who may have been exposed to a communicable disease if permitted by law.

Disclosures about victims of abuse, neglect, or domestic violence. We may disclose your health information to a government authority if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

Disclosures for judicial and administrative proceedings. Your protected health information may be disclosed in response to a court order or in response to a subpoena, discovery request, or other lawful process if certain legal requirements are satisfied.

Disclosures for law enforcement purposes. We may disclose your health information to a law enforcement official as required by law or in compliance with a court order, court-ordered warrant, a subpoena, or summons issued by a judicial officer; a grand jury subpoena; or an administrative request related to a legitimate law enforcement inquiry.

Disclosures regarding victims of a crime. In response to a law enforcement official's request, we may disclose information about you with your approval. We may also disclose information in an emergency situation or if you are incapacitated if it appears you were the victim of a crime.

Disclosures to avert a serious threat to health or safety. We may disclose information to prevent or lessen a serious threat to the health and safety of a person or the public or as necessary for law enforcement authorities to identify or apprehend an individual.

Disclosures for specialized government functions. We may disclose your protected health information as required to comply with governmental requirements for national security reasons or for protection of certain government personnel or foreign dignitaries.

OTHER USES AND DISCLOSURES

We will obtain your express written authorization before using or disclosing your information for any other purpose not described in this notice. For example, authorizations are required for use and disclosure of psychotherapy notes, certain types of marketing arrangements, and certain instances involving the sale of your information. You may revoke such authorization, in writing, at any time to the extent we have not relied on it.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

Right to Inspect and Copy. You have the right to inspect and copy health information maintained by us. To do so, you must complete a specific form providing information needed to process your request. If you request copies, we may charge a reasonable fee. We may deny you access in certain limited circumstances. If we deny access, you may request review of that decision by a third party, and we will comply with the outcome of the review.

Right to Request Amendment. If you believe your records contain inaccurate or incomplete information, you may ask us to amend the information. To request an amendment, you must complete a specific form providing information we need to process your request, including the reason that supports your request.

Right to an Accounting of Disclosures and Access Report. You have the right to request a list of disclosures of your health information we have made, with certain exceptions defined by law. You also may request an access report indicating who has accessed your PHI maintained by us or our business associates in an electronic designated record set in the last three years. To request an accounting, you must complete a specific written form providing information we need to process your request.

Right to Request Restrictions. You have the right to request a restriction on our uses and disclosures of your health information for treatment, payment, or health care operations. You must complete a specific written form providing information we need to process your request. Our Privacy Officer is the only person who has the authority to approve such a request.

Right to Request Alternative Methods of Communication. You have the right to request that we communicate with you in a certain way or at a certain location. You must complete a specific form providing information needed to process your request. Our Privacy Officer is the only person who has the authority to act on such a request. We will not ask you the reason for your request, and we will accommodate all reasonable requests.

COMPLAINTS

If you believe your rights with respect to health information have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact us at:

Audiology Associates of DFW
3132 Matlock Road #303
Arlington, Texas 76015

Owner, Koble Hearing PLLC, Marylyn Koble
Privacy Officer, Kellie Lorensen

All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

We reserve the right to change the terms of this Notice and to make the revised Notice effective with respect to all protected health information regardless of when the information was created.