

Adult Case History

Patient Name: _____ Birth Date: _____

Address: _____
Address City State Zip

Who referred you to us? _____

Ear History Please circle one yes or no

Yes	No	Do you have trouble hearing? Circle one: Both ears	Right ear	Left ear
Yes	No	Have you seen an ENT physician for your hearing?		
Yes	No	Have you ever had ear surgery? If yes, type of surgery	_____	
Yes	No	Have you ever had your hearing tested?	Yes	No
Yes	No	Recent sudden change in hearing?	Yes	No
Yes	No	Recent ear pain?	Yes	No
Yes	No	Fallen in past year?	Yes	No
Yes	No	Recent ear discharge?	Yes	No
Yes	No	Facial numbness?	Yes	No
Yes	No	Dizziness in past 90 days?	Yes	No
Yes	No	MRI/CT of head or ears?	Yes	No
			Yes	No

Other health history: Do you have any of the following?

Yes	No	Diabetes	Yes	No	Macular degeneration
Yes	No	Headaches	Yes	No	Currently use tobacco
Yes	No	Head trauma	Yes	No	Kidney disease
Yes	No	Implantable electrical device	Yes	No	Heart Disease
Yes	No	Cancer If yes, type: _____	Yes	No	High blood pressure
Yes	No	Radiation to head or neck	Yes	No	Blood thinners
Yes	No	Chemotherapy	Yes	No	Depression
Yes	No	Compromised immune system	Yes	No	Anxiety
Yes	No	Stroke or TIA	Yes	No	Dementia
Yes	No	Arthritis	Yes	No	Memory loss

List other surgeries/medical conditions _____

ABOUT YOUR HEARING: Do you experience difficulty with the following?

Yes	No	Understanding conversation in quiet	Yes	No	In a restaurant
Yes	No	Hearing in a groups	Yes	No	In a store
Yes	No	Hearing on the phone	Yes	No	In a car
Yes	No	Hearing the TV	Yes	No	Withdrawing from social settings
Yes	No	Hearing at church	Yes	No	Stress at home because of hearing
yes	No	In noisy places			

List your most challenging hearing situation: _____

Signature _____ Date: _____

Signature _____ Date: _____

Signature _____ Date: _____

Signature _____ Date: _____

Typing your name above acts as your electronic signature and confirms your agreement to this document

Receipt of Notice of Privacy Practices

Name: _____

Emergency Contact: _____ Phone: _____

Authorization to release information

I give permission for Advanced Audiology Concepts to release information and or discuss my case, hearing aids and any other related issues with the following individual/s:

Name:

Phone:

_____	_____
_____	_____
_____	_____
_____	_____

Receipt of Notice of Privacy Practices

I acknowledge that I have been offered a copy of Advanced Audiology Concepts' Notice of Privacy Practices.

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Patient's Signature: _____ Date: _____

Claim Submission Form

I hereby authorize Advanced Audiology Concepts, Inc. to submit claims for payment to my insurance company for payment. I request that payment of authorized benefits be made on my behalf to Advanced Audiology Concepts, Inc. for any service furnished to me. I authorize release of information about me to insurance companies if needed to determine payment for related services. I understand that I am responsible for balances such as co-pays, deductibles and co-insurance amounts, as well as charges for uncovered services and/or products.

Authorized Signature _____ Date: _____

Authorized Signature _____ Date: _____

Authorized Signature _____ Date: _____

Authorized Signature _____ Date: _____

Authorized Signature _____ Date: _____

Typing your name above acts as your electronic signature and confirms your agreement to this document

HHI Questionnaire

Instructions

Answer YES, SOMETIMES or NO for each question. Do not skip a question if you avoid a situation because of a hearing problem. If you use hearing aids, please answer according to the way you hear with your hearing aids.

Date: _____

YES Sometimes NO

- | | | | | |
|-----|--|--------------------------|--------------------------|--------------------------|
| 1. | Do you use hearing aids? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | Does a hearing problem cause you to feel embarrassed when meeting new people? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | Does a hearing problem cause you to feel frustrated when talking to family members? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | Do you have difficulty hearing a store clerk? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | Do you feel handicapped by a hearing problem? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | Does a hearing problem cause you difficulty when visiting with people? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | Do you not attend religious services because of your hearing? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | Does a hearing problem cause you to have arguments with family members? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | Does a hearing problem cause you difficulty when listening to TV? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | Do you feel difficulty with your hearing limits or hampers your personal or social life? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. | Does a hearing problem cause you difficulty when in a restaurant? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Modified HHIE 0-8= No HH, 10-24= Mild to moderate HH, 26-40= Severe HH Adapted from Ventry I., Weinstein B., Identification of elderly people with hearing problems. ASHA, 1083; 25:37-42

Notice of Privacy Practices

Who Follows the Privacy Practices in this Notice?

All employees, trainees, students, volunteers, and agents of Advanced Audiology Concepts, Inc (“AAC”) must follow these practices.

Our Commitment to Your Privacy

AAC is committed to maintaining the privacy of your health information in all formats (electronic, paper or verbally). We keep your information in a secure health record. We will only use or disclose (share) your health information as described in this notice.

How We May Use and Share Your Health Information with Others?

We may use and share your health information for treatment, payment, and health care operation purposes. We may use and share health information with other health care providers who are treating you or with a pharmacy that is filling your prescription; We and share your health information with your health insurance plan to get pre-approval for your treatment or to collect payment care services; or We may use and share your health information to run our business, to evaluate practitioner or provider performance, educate health care professionals.

We may share your health information with business associates such hearing aid manufactures and those who help us collect payment services. All of our business associates are required to protect the privacy and security of your health information.

We may use and share your health information to contact you about health-related benefits, services, newsletters and new product information. You must opt in to receive newsletters, new product information and other materials such as birthday cards.

We may also use and disclose your health information for the following reasons: For public health activities (for example, to report diseases, births and deaths to a public health official authorized to receive such information); For workers’ compensation or similar programs that provide benefits for work-related injuries; To alert appropriate authorities about victims of abuse, neglect, or domestic

violence; if we reasonably believe that you have been a victim of such abuse, neglect, or domestic violence, we will make every effort your permission before sharing this information. However, in some cases we may be required or authorized to act without your permission;

For oversight by government or private agencies that review health care organization’s practices to ensure safety and quality activities; monitoring products which may need repair or are being recalled (for example, to satisfy FDA requirements); To create and disclose (does not have your name, SS#, etc.) health information or limited data sets that do not have direct identifiers about you; judicial and administrative proceedings (for example, a court order); For law enforcement purposes (for example, to identify or find suspect or missing person, or to report a crime that occurred on or off our property); To coroners, medical examiners, or funeral as necessary to do their jobs; To organizations that handle organ, ear or tissue donation; To avoid a serious threat to health or public safety; For specialized government functions; Incidental uses and disclosures (for example, if a patient or staff member overhears discussion at the front desk even when reasonable steps were taken to keep your information confidential); and As otherwise required allowed by local, state or federal law.

If you give us permission, we may use or share your health information for: Payment for your care such as a family member assisting payment Uses and disclosures of your health information that involve marketing, payments from a third party, or any other use or disclosure not described in this notice or required by law will only be made with your written authorization (permission). You have to withdraw (take back) your authorization, except when we have already relied on it, by contacting our privacy official provided **What Rights do you have About Your Health Information?**

Although your health record is the property of AAC, you have the right to: Request restrictions on how we use or share your information treatment, payment, and health care operations, and how we may share it with your family and friends. We are not required to agree your request, except when you pay for services out-of-pocket, in full and request

us not to share the health information with your insurance plan. Request confidential communications of your health information. Review and copy health information in your medical billing records upon written request. If you request an electronic or paper copy of your health information, one will be provided within 3 to 10 days of your request. You may be charged no more than .75¢ per page for paper copies. For electronic copies, we charge you a reasonable fee for using electronic media. Request amendment (changes) to information in your medical and billing You must make your request to change, in writing and provide a reason for the request. We are not required to agree to your request will let you know in writing, and state a reason, when we do not agree. If we agree, your suggested amendment will be added to record. Receive an accounting of disclosures. An “accounting of disclosures” is a report that identifies certain other people or organizations

to which we have disclosed your health information without your authorization. (See the section on “We may also use and disclose health information for the following reasons” for an explanation of who might be included.) You have a right to receive one accounting disclosures every 12 months without charge; however, we may charge you for the cost of providing any additional accounting in 12-month period. Name a personal representative who may act on your behalf to control the privacy of your health information. and guardians will generally have the right to control the privacy of health information of minors (children under 18 years old) unless minors are permitted by law to act on their own behalf. There may also be exceptions to this per individual state law. Ask for and paper copy of this notice. Request additional privacy protections with respect to your electronic medical record.

Requests must be made in writing to the privacy official or appropriate doctor’s office or hospital department. For more information get a designated request form, please contact the privacy official provided below.

What are Our Duties about Your Health Information and this Notice?

We are required by federal and state law to keep the privacy and security of health information that may tell your identity. If there breach of privacy that compromises your identifiable health information, we will notify you in writing or by email.

We are required to provide you with a copy of this notice and agree to the terms of this notice. We reserve the right to change the this notice; the revised notice will be effective for all health information that we keep. We will post any revised notices on our public

website at www.aacHEAR.org and in admitting or waiting room areas. You may also request a paper copy of the revised notice at of your next visit.

If you have any questions about this notice or believe your privacy rights have been violated, please contact us at:

Advanced Audiology Concepts, Inc

8897 Mentor Ave.

Mentor, Ohio 44060 440-205-8848

You may also contact the Secretary of the United States Department of Health and Human Services. We will not retaliate or take against you for filing a complaint.

REQUEST FOR ACKNOWLEDGMENT

An acknowledgment form will be printed for you to sign during your registration process. By signing the Notice of Privacy Practices

Acknowledgment Form, you are confirming that you have received a copy of this notice.

This notice is effective as of 02-03-14. Updated 11-23-2020



Date: _____

Name: _____ Consent for Treatment

DOB: _____

I voluntarily give my permission to the health care providers of Advanced Audiology Concepts, Inc and such assistants, aides, Audiology Doctoral students and other health care providers ("Providers") as they may 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 Advanced Audiology Concepts, or until I withdraw my consent in writing.

I understand that all information shared with the clinicians at Advanced Audiology Concepts, Inc 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 include the following:

- A. When there is 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 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, and to inform the proper authorities.
C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.
D. When your insurance requires reporting of your information.

I understand that Advanced Audiology Concepts, Inc services are provided by a range of Providers, some of whom may be in training. All professionals-in-training are supervised by licensed audiologist.

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

Signature

Date

Typing your name above acts as your electronic signature and confirms your agreement to this document