Patient Information

Demographics:

Patient Name ________________________________ Date of Birth ______/______/_______ Male Female

SSN: XXX-XX-_________ Home Phone (______) ______-________ Cell Phone (______) ______-________

Address _________________________________ City _____________________ State _____ Zip __________

Marital Status: S M D W Spouse's Name _______________ _____

Primary Care Physician (Required**) ___________________________ Phone (______) ______-________

Make/Model of Cell Phone _____________________________ Preferred method of contact: Call Text Email

Emergency Contact:

Name____________________________ Phone (______) ______-________ Relation to Patient _______________

How did you hear about us? Please circle all that apply and provide names where applicable.

Physician (specify) ______________________ Friend or Family Member (specify) ______________________

Mail Newspaper Website Google Facebook KBEST KBYG Other: ___________________

Employer:

Name of Business______________________________________ Phone (_____) _____-_______ ____Retired

Patient Portal:

Would you like us to activate your secure, online patient portal (to view reports, invoices, etc.)? **Yes No**

If yes, please provide your email ____

Do you authorize Pathway Audiology to send you educational emails about hearing loss, tinnitus, and hearing aids; promotional products; and/or clinic events? **Yes No**

Responsible Party Signature (Required**) _________________________________ Date _____________

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for use of the information for treatments, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

How may we contact you to confirm appointments? (Please circle all that apply) CALL TEXT EMAIL

May we leave a message or send you a text on your home or cell phone? YES NO

May records be released to or discussed with a member of your family? YES NO

If YES, please name the family members we are allowed to discuss with (please include yourself if filling out for your dependent**):

Name: ___________________________________ Relation: __________________ Phone Number: (_____) _____-_______

Name: ___________________________________ Relation: __________________ Phone Number: (_____) _____-_______

Name: ___________________________________ Relation: __________________ Phone Number: (_____) _____-_______

This consent was signed by: ____ (PLEASE PRINT)

____ ____________________

Patient Signature **Date**

____ ____________________

Staff Signature **Date**

210 West 3rd Street
Big Spring, TX 79720
(432) 606-1933

Marisha Beck, Au.D., CCC-A, CH-TM, TX Lic: 80110
Ashley Smith, Privacy Official

Patient Authorization

Clinical

1. I authorize Pathway Audiology, PLLC to perform all recommended/referred diagnostic procedures.
2. ____ I authorize Pathway Audiology, PLLC to complete all measures needed to make a thorough diagnosis and recommendation. I authorize that such diagnostic material may be released to and/or obtained from third-party payors and/or other health professionals. This includes my primary care physician as listed on the Patient Information form and/or other healthcare professionals (listed as follows), as necessary: ____

Financial

3. I authorize Pathway Audiology, PLLC to furnish all information regarding my medical history, diagnosis and treatment of myself to an insurance company regarding my claim for benefits. If, however, said insurer fails to meet this obligation in whole or in part, or if I am non-insured, I agree to be responsible to the fee and cost involved in my treatment. I authorize payment of medical benefits to Pathway Audiology, PLLC and further understand that should my account have to be referred to a collection agency that I am responsible for all fees and costs incurred therein. I hereby authorize Pathway Audiology, PLLC to act on my behalf in accessing medical records when and if needed.

Insurance

4. I authorize Pathway Audiology, PLLC to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records and other diagnostic material about my medical history, services rendered, or recommended treatment. I authorize Pathway Audiology, PLLC to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company on my behalf and in my name listed as "signature on file".
5. I certify that I, and/or my dependents, have insurance coverage with ________________________ and assign directly to Pathway Audiology, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
6. The above named may use my healthcare information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____ ____________________

Patient Signature **Date**

210 West 3rd Street
Big Spring, TX 79720
(432) 606-1933

Marisha Beck, Au.D., CCC-A, CH-TM, TX Lic: 80110

Hearing Handicap Inventory
Screening for Adults

	NO	SOMETIMES	YES
Does a hearing problem cause you to feel embarrassed when you meet new people?			
Does a hearing problem cause you to feel frustrated when talking to members of your family?			
Do you have difficulty hearing/understanding co-workers, clients or customers?			
Do you feel handicapped by a hearing problem?			
Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?			
Does a hearing problem cause you difficulty in the movies or in the theatre?			
Does a hearing problem cause you to have arguments with family members?			
Does a hearing problem cause you difficulty when listening to TV or radio?			
Do you feel that your hearing problem limits or hampers your personal or social life?			
Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?			

If we find your hearing challenges could be helped by hearing devices, would you be open to trying a solution?   YES   POSSIBLY   NO

Please check hearing aid features you may be interested in:

____Invisibility   ____Maintenance-Free   ____Bluetooth/Smart Phone Streaming

____Rechargeability   ____Cost-Effective   ____Hearing in Noise

Case History

HEARING HISTORY:	YES	NO
Is this your first hearing test?		
Have you ever had ear surgery?		
Do you have any pain in your ears?		
Do you have a history of ear infections?		
Do you have a family history of hearing loss?		
Do you have a history of noise exposure?		
Do you have noises in your ears? (i.e. ringing, roaring)		
If so, is it bothersome?		
Have you taken medication that may have affected your hearing?		
Have you noticed dizziness?		
Do you think you have a hearing loss?		
Do you have concerns with memory loss?		
Do you have issues with dexterity? (fine motor skills in hands)		
HEARING AID HISTORY:		
Have you tried hearing aids before?		
Are you currently a hearing aid user?		
Were you satisfied with your hearing aids?		

For office use only:

MEDICAL HISTORY: Please check all that apply

___Heart ___Current use of blood thinner ___Pace Maker

___Allergies ___Cancer ___Diabetes Other ______________________

Do you have difficulty hearing on your cell phone? YES NO

Do you know any patients of Pathway Audiology? YES NO

If yes, who do you know? __________________________________

Please list situations in which you would like to hear and/or understand better:

________________________ ________________________ ________________________

Was there any specific event or circumstance that brought you in today?

____

Is there anything else we should know?

____