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Ascent AUDIOLOGY & HEARING

Confidential Client Information

1 Patient Information

Name: _____ Date: _____

Address: _____ DOB: _____ Age: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Marital Status: ☐ Single ☐ Widowed ☐ Married Name of Spouse: _____

Gender: _____ Occupation: _____

Primary Insurance: _____ Insured Name: _____ Insured DOB: _____

How did you hear about us? ☐ Patient ☐ Newspaper ☐ Direct Mail ☐ Community Event ☐ Physician Referral
☐ Website ☐ WSAZ Commercial ☐ Interview ☐ Other _____

Emergency Contact Name: _____ Phone: _____

2 Medical History

Have you seen a doctor specializing in diseases of the ear: ☐ Yes ☐ No

Name of primary care or referring physician: _____

Have you ever had ear surgery: ☐ Yes ☐ No By whom: _____

Have you ever had your hearing tested: ☐ Yes ☐ No By whom: _____

Is there diabetes in your family: ☐ Yes ☐ No

Are you taking blood thinners: ☐ Yes ☐ No Do you wear a pacemaker: ☐ Yes ☐ No

Do you take prescription drugs daily, if so please list: _____

3 About Your Hearing

Please complete backside ➤

Do you have a deformity of the ear?	☐ Yes ☐ No
Do you have any pain in your ears?	☐ Yes ☐ No
Sudden or rapid hearing loss in the past 90 days?	☐ Yes ☐ No
Sudden or long-term dizziness?	☐ Yes ☐ No
Hearing loss in one ear in the last 90 days?	☐ Yes ☐ No
Have you seen a doctor for wax removal?	☐ Yes ☐ No
Drainage from either ear in the past 90 days?	☐ Yes ☐ No
Which is your poorer ear?	☐ Right ☐ Left ☐ Same

Do you have ringing or other noises in your ear(s)? if so which side? ☐ Right ☐ Left ☐ Both

Does anyone else in your family have a hearing problem: ☐ Yes ☐ No Who: _____

In what environment does your hearing problem give you the most trouble: _____

4 Hearing Aid Experience

☐ I have a hearing aid and use it regularly in my:
☐ Right ear ☐ Left ear

☐ I have a hearing aid, but don't use it, or use it only occasionally.

☐ I have tried a hearing aid but returned it.

☐ I have inquired about hearing aids at another office(s), but did not purchase at that time.

☐ I have never used a hearing aid.

5 Self Questionnaire

Please answer "yes, "no", or "sometimes" to each of the following items.
Do not skip a question if you avoid a situation because of a hearing problem.
If you wear a hearing aid(s), please answer the way you hear without the hearing aid(s).

	Yes	No	Sometimes
1. Does your hearing problem cause you to feel frustrated when visiting with friends, relatives or neighbors?	☐	☐	☐
2. Does your hearing problem cause you to feel embarrassed when meeting with new people?	☐	☐	☐
3. Do you have difficulty hearing when someone is soft spoken or speaks at a distance?	☐	☐	☐
4. Does your hearing problem cause you to attend social events or religious services less often than you would like?	☐	☐	☐
5. Does your hearing problem cause you to become fatigued by the end of the day?	☐	☐	☐
6. Does your hearing problem cause you difficulty when listening to the TV or radio?	☐	☐	☐
7. Does your hearing problem cause you difficulty when in a restaurant with relatives or friends?	☐	☐	☐
8. Does your hearing problem cause you to have arguments with family members?	☐	☐	☐

6 Motivation Scale

On a scale of 1-10, where do you feel you are (psychologically, emotionally, financially, etc.) regarding doing something about your hearing loss? (Please circle one)

1 2 3 4 5 6 7 8 9 10

Not Motivated ..... Very Motivated

7 Hearing Needs Assessment

Please rank the following factors in accordance with how important they are to you when deciding to purchase a hearing aid.

With a '1' being most important and a '4' being least important (Remember to use a 1, 2, 3 or 4.)
These are your choices:

_____Sound Quality & Clarity _____Durability/Reliability _____ Cost _____ Appearance

What motivated you to come in today? _____

9 Release & Authorization

By checking this box and signing below, you allow Ascent Audiology & Hearing to release all medical information to your insurance carrier(s). You also agree to accept financial responsibility for all charges which are not covered and thus not paid to Ascent Audiology & Hearing by your insurance carrier(s) for services rendered by our office. This release is valid for life but may be revoked in writing at any time. Refusal to sign or revocation of this release will result in you being financially responsible for payment in full at the time of the visit.

Signature of Patient or Guarantor: _____ Date: _____

Patient Consent & Acknowledgment

Ascent AUDIOLOGY & HEARING

Consent to Release Information

Authorization for Release of Protected Health Information to a Trusted Individual

_____ Initial

By initialing this paragraph, I authorize Tri-State Hearing Services, LLC dba Ascent Audiology & Hearing to communicate with the Trusted Individual(s) named below about my prognosis and treatment plans, diagnosis, test findings, reports and invoices related to my healthcare.

Physician Name: _____

Friend or Family Member

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Consent to Communicate electronically between Patient and Ascent Audiology & Hearing Staff

_____ Initial

By initialing this paragraph, I agree to receive appointment reminders, office information including but not limited to location information, hours of operation, change of address, hardware & software update notifications, real-time telehealth connectivity and recording, remote programming and counseling sessions, marketing information & promotions, diagnostic information, or other information or forms via the internet, email, or text.

_____ Initial

I agree that I will NOT use email or text to communicate any urgent matters to the staff of Ascent Audiology & Hearing. I understand that email sent from Ascent Audiology & Hearing is potentially accessible to third parties. I also understand that on my end, anyone who has access to my email account or my unsecured electronic devices will potentially have access to communication sent between Ascent Audiology & Hearing and myself.*

Assignment of Benefits

_____ Initial

I am aware that by initialing this section, I am authorizing Ascent Audiology & Hearing to bill my insurance benefits to be paid directly to Ascent Audiology & Hearing I also authorize the release of any information required to process this claim. I agree to accept final responsibility for all charges which are non-covered and thus not paid to Ascent Audiology & Hearing by my insurance carrier(s) for services rendered by Ascent Audiology & Hearing.

Written Acknowledgment of Notice of Privacy Practices Offered:

_____ Initial

By initialing this paragraph, I acknowledge that I have been offered a copy of Ascent Audiology & Hearing Notice of Privacy Practices.

Signature: _____ Date: _____ / _____ / _____
Month Day Year

***Ascent Audiology & Hearing is committed to keeping your email address confidential.**

Notice of Privacy Practices

Effective Date: January 1, 2024

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. About this Notice

This Notice of Privacy Practices ("Notice") describes how we may use and disclose your protected health information ("PHI") to carry out treatment, payment, and health care operations and for other purposes that are permitted or required by law. PHI for purposes of this Notice, is generally any information that identifies you and is created, received, maintained, or transmitted by us in the course of providing health care items or services to you. This Notice also describes your rights and our duties with respect to your PHI.

We are required by the Health Insurance Portability and Accountability Act, as amended, ("HIPAA") and other applicable laws to maintain the privacy of PHI to provide notice of our legal duties and privacy practices, and to notify affected individuals following a breach of unsecured PHI. We are required to abide by the Notice currently in effect. You have a right to receive a paper copy of this Notice.

We reserve the right to change this Notice and make the new Notice apply to PHI we already have as well as any information we receive in the future. A revised Notice will be posted at our facilities and on customer service websites. This Notice applies to providers and facilities that are owned/operated by Tri-State Hearing Services, LLC dba Ascent Audiology & Hearing.

2. How We May Use and Disclose Your PHI

The following describes ways we may use or disclose your PHI that do not require your written authorization (except as otherwise noted).

TREATMENT: This includes providing services to you; coordinating your care with other providers; sending you appointment reminders and information about new or alternative treatments; and consulting with others, including hearing aid manufacturer representatives, to assist in the selection, fitting, programming, or adjustment of your hearing aids.

PAYMENT: This includes billing for services provided to you so that payment may be obtained from you, an insurance company or health plan, or other third party, or collecting unpaid amounts.

HEALTH CARE OPERATIONS: This includes activities that allow us to run our business and to ensure that you receive quality care, such as quality assessment, performance reviews, business planning, and training programs.

OTHER HEALTH-RELATED COMMUNICATIONS: This includes sending you information about health-related products or services we provide that we believe may benefit your hearing health care and similar communications as allowed by law.

PEOPLE ASSISTING IN YOUR CARE OR PAYMENT FOR YOUR CARE: Unless you object, we may share limited relevant health information with a person such as a family member or friend who is involved in your health care or payment for your care. We may, for example, provide limited information to allow another person to pick up a hearing aid for you. If you do not want such information given out, you can request that it not be shared. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

FUNDRAISING/FOUNDATION: We may contact you about fundraising programs and events. We may disclose limited PHI to companies that help us with these programs. You have the right to opt out of receiving such communications.

RESEARCH: We may share your health information for research purposes if allowed by law or if you have given permission.

OTHER SITUATIONS: We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

2. How We May Use and Disclose Your PHI *Continued*

Examples include:

- Emergency treatment or disaster relief assistance
- Public health reporting activities or risks, such as contagious disease reporting or notices to and from the Food and Drug Administration regarding medical devices
- Health oversight activities (audits, investigations, inspections, licensure, compliance)
- Reports regarding victims of abuse, neglect or domestic violence
- Judicial and administrative proceedings, such as in response to a court or administrative order or subpoena
- To avert a serious threat to health or safety
- Law enforcement, subject to limits set forth under the law
- Military and veterans, if lawfully required by military command authorities
- Workers' compensation
- National security and intelligence activities, as authorized by law
- Inmates or persons in custody (for health care or other safety or security reasons)
- Business associates (to perform functions or services on our behalf)
- When otherwise permitted or required by law

  The use or disclosure of your PHI for marketing purposes or sale of your PHI is prohibited unless you have given us prior written authorization. "Marketing" does not include face-to-face communications or promotional gifts of nominal value. Other uses and disclosures of your PHI not covered by this Notice or by the laws that apply to us will be made only with your written authorization. You may revoke your authorization at any time by submitting a written revocation. However, any disclosure we made in reliance on your authorization before you revoked it will not be affected by the revocation.

3. Your Rights

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS: You have the right to request, in writing, that we communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. We will accommodate all reasonable requests.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request a restriction on the PHI we use or disclose for treatment, payment, or health care operations; or to request a limit on the PHI we disclose to someone involved in your care or payment for your care. For example, you may ask us not to share information about a particular diagnosis or treatment with a family member. You must make your request in writing. We are not required to agree to your request, except for a request relating to "Out-of-Pocket Payment in Full" as described below.

OUT-OF-POCKET PAYMENT IN FULL: If you (or a friend or family member) paid out-of-pocket in full for a specific health care item or service, you have the right to ask that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations. We will honor that request.

RIGHT TO INSPECT AND COPY: You have a right to look at and get a copy of your health information. You must make your request in writing. If your PHI is maintained in an electronic format, you have the right to request that an electronic copy of such record be given to you or transmitted to another person or entity. We may charge you a reasonable cost-based fee for providing a paper copy or transmitting an electronic record.

RIGHT TO AMEND: If you believe that some PHI we have is incorrect or incomplete, you may request, in writing, that we amend the information. If we deny your request, we will send the denial in writing, including the reasons and the steps you may take in response.

RIGHT TO AN ACCOUNTING OF DISCLOSURES: With some exceptions, you have a right to request, in writing, a list of disclosures of your PHI made by us or our business associates. This does not include disclosures made for treatment, payment, or health care operations purposes.

4. Questions or Complaints

You may contact our Privacy Officer at: Tri-State Hearing Services, LLC dba Ascent Audiology & Hearing.

Attn: Rebecca Brashears
906 6th Avenue, Huntington, WV 25701
(304) 948-5565
privacy@ascentaudiologywv.com

If you believe your privacy rights have been violated or you disagree with a decision about any of your rights, you may contact us or the U.S. Department of Health and Human Service - Office of Civil Rights (OCR) to file a complaint. For more information go to www.hhs.gov/ocr/privacy/hipaa/complaints. You will not be retaliated against for filing a complaint.