Miracle-Ear®

Confidential Record Form

Name: _____ **Date:** _____
First Last Initial

Birthdate: _____/_____/_____ **Age:**_____ □ **Male** □ **Female**
□ **Married** □ **Single** □ **Widow(er) Companion:** _____
Permanent Address_____
Street **City** **State** **Zip**

Seasonal Address _____
Street **City** **State** **Zip**

Phone- Home:_____ **Cell** _____ **Work:** _____
Email Address: _____ **How many children do you have?** _____
Occupation: _____ **If retired, what was your occupation?** _____

Family Contact:_____ **Phone:**_____ (Not living with you)
Name Relationship

Family Physician Name: _____

Family Physician Address: _____
Street City State Zip

Would you like a copy of your test sent to your doctor? □ Yes □ No

Primary Insurance Provider: _____

Referral Source (Check One):

□ Doctor Referral □ Patient Referral □ Friend/Family □ Television □ Mail
□ Yellow Pages □ Store Sign □ Newspaper □ Walk-In □ Other: _____

Do you have any allergies? □ No □ Yes Please List: _____
Do you have arthritis? □ No □ Yes
Are you diabetic? □ No □ Yes
Are you taking medications? □ No □ Yes Please list: _____
Have you received medical or surgical treatment for a hearing loss? □ No □ Yes

If yes, when? _____ Physician/ENT: _____ Phone: _____

Address:_____
_____

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Confidential Patient Analysis Chart

History of Hearing Loss: Please check Yes or No

1. Are you experiencing ear pain? □ Yes □ No
2. Have you ever had ear surgery? □ Yes □ No
3. Do you have ringing in your ears? □ Yes □ No
4. Will this be your first hearing test? □ Yes □ No
   If no, when was your last hearing test?_____
5. In which ear is your hearing most impaired? □ Left □ Right
6. Did your hearing impairment develop: □ Suddenly □ Gradually
7. Have you experienced acute or chronic dizziness? □ Yes □ No
8. Do you have a family history of hearing loss? □ Yes □ No □ Unsure
9. Do you think you know the cause of your hearing loss? □ Yes □ No
   If yes, what do you think caused your hearing loss?_____
10. Have you noticed any change in your ability to remember? □ Yes □ No
11. Have you been examined by a doctor in the past six months? □ Yes □ No
12. Has hearing in one or both ears rapidly decreased within the past 90 days? □ Yes □ No
13. Do you have a history of active drainage from your ears within the past 90 days? □ Yes □ No

History of Communication Issues

14. Do you often ask others to repeat? □ Yes □ No
15. Do you ever have difficulty hearing on the phone? □ Yes □ No
16. Do you ever have difficulty hearing your spouses voice? □ Yes □ No □ N/A
17. Do others ever mention that you turn the television or radio up too loud? □ Yes □ No
18. Do you find it difficult to understand conversation in noisy places? □ Yes □ No
19. Does a hearing impairment hamper your personal/social life? □ Yes □ No
20. If a hearing loss is discovered, and may be helped, are you ready for help? □ Yes □ No
21. Do you ever HEAR conversation loud enough, but cannot understand words? □ Yes □ No
22. If you need hearing aids, is it important to you that they not be visible? □ Yes □ No
23. What comments have others made about your hearing? _____

History of hearing aid use

24. Do you wear hearing aids in your □ Left □ Right □ Both Ears
25. If so, might you be experiencing any difficulties with your hearing aids? Please explain:

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Confidential Spousal/Companion Questionnaire

Your Name:_____Date: _____
Patient Name:_____ Relationship:_____

History and Communication Symptoms

Please answer the following:

1. **Does your companion ever complain of ringing in the ears? Yes □ No □**
2. **Does your companion have difficulty hearing while in a car? Yes □ No □**
3. **Does your companion have difficulty hearing on the telephone? Yes □ No □**
4. **Does your companion have difficulty hearing when there is noise present? Yes □ No □**
5. **Did your companion's hearing impairment develop: Suddenly □ Gradually □**
6. **When did you first suspect your companion had hearing difficulties? _____year(s) ago**
7. **Have you noticed any change in your companion's ability to remember? Yes □ No □**
8. **Does your companion turn the television up louder than normal? No □ A little □ A lot □**
9. **Does your companion accuse you of mumbling? Yes □ No □**
10. **Does your companion talk louder than normal? No □ A little □ A lot □**
11. **Does your companion avoid social gatherings? Yes □ No □**
12. **Do you ever not talk because your companion will not hear you anyways? Yes □ No □**
13. **Are you concerned that a hearing problem causes him/her difficulty when visiting friends, relatives, or neighbors? Yes □ No □**
14. **Does your companion's hearing problem cause you stress? Yes □ No □**
    If yes, how so?_____
15. **Are you ever embarrassed by your companion's inability to hear? Yes □ No □**
16. **Do you think your companion needs hearing help? Yes □ No □**
17. **Would your life be more enjoyable if your companion heard better? Yes □ No □**

If your companion currently wears hearing aids

18. **If your companion wears hearing aids, how often does he/she wear them? _____**
19. **Might they be experiencing any difficulties with their hearing aids?**
    Explain: _____
20. **Is there any additional information you would like us to know or address?**

_____

_____

_____

Insurance Liability for Payment:

Your health insurance company will only pay for services that it determines to be “reasonable and customary.” Every effort will be made by this office to have all services preauthorized, when necessary, by your health insurance company. If your health insurance company determines that services are not reasonable and customary, or that a particular service is not covered under your plan, your health insurance company will deny payment.

Beneficiary Agreement:

I understand that my health insurance company may deny payment for the services provided by Miracle-Ear (Health Services, LLC). If my health insurance company denies payment for any reason, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make any payment for services provided, that I am responsible for any and all remaining balances for non-covered services, deductibles, co-payments or coinsurance’s that may apply.

_____

Patient’s Signature Date

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

By my signature below I acknowledge that I have received the HIPAA Notice of Privacy Practices (the "Notice") from Health Services, LLC ("Health Services, LLC") and that I have been provided an opportunity to review it.

I understand that I have certain rights to privacy regarding my protected health information.

I understand that Health Services, LLC can and will use my health information for purposes of my treatment, payment for treatment and health care operations.

I have read and understand that Health Services, LLC may use and share my protected health information for other purposes, as described in the Notice.

I understand that I have rights regarding my protected health information as listed in the Notice.

I understand that Health Services, LLC has the right to change the Notice from time to time and I can obtain a current copy of the Notice from Health Services, LLC at any time.

_____ _____

Patient/Patient's Representative Signature Date

Patient Name (First, MI, Last): _____

Patient Date of Birth (MM/DD/YY): _____

If you are signing as the Patient's representative:

Print your name (First, MI, Last): _____

Describe your authority: _____

_____

_____

Internal Use Only: **Good Faith Effort to Obtain Acknowledgement Form** Patient Name: Date:
I attempted to obtain the patient's (or their representative's) signature on this Notice of Privacy Practices Acknowledgement Form, but was unable to do so as documented below: Reason:
Name: Signature: