ACI Hearing & Balance Center, Inc.
An Audio- Vestibular Laboratory
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Doctors of Audiology

Today's Date:_____Preferred method of contact: (circle) Phone or Text or Email

Name:_____ Age:_____Gender:___ DOB:_____
(First, Middle, & Last)

Address:_____Social Security Number:_____

City _____State_____Zip_____Phone hm_____Phone wk_____

Cell: _____Cell Phone Carrier_____ Email:_____

Family Dr.:_____Referred by Dr.:_____Referred for:_____

Responsible Party:_____DOB_____

SSN:_____Phone_____Email_____

INFORMED CONSENT AGREEMENT

I, the undersigned, understand that the evaluation of the hearing (auditory) system requires the use of specialized instrumentation During the course of the evaluation, I understand that various earphones or acoustic probes will be placed over my ears or in my ea canals. Acoustic (sound) signals will be delivered to the ears through either of these types of earphones. Some of the sounds will be loud but scientific evidence has shown that these loud sounds will not cause any damage to the ear or to the hearing. In the event of amplificatior or other custom devices, I consent to the placement of foam or cotton blocks in the external ear canals as well as materials (silicon) tc make ear impressions. In the case of Balance testing and/or ABR Testing, alcohol wipes will be used to clean the area of the skin tha taped electrodes will be placed. These electrodes do not deliver any type of electrical signal to you, they only measure the electrica activity normally generated by the body. Additionally, for Balance testing, water will be placed into the ear canals through a smal irrigator tube to measure the strength of each ears response to the water temperature.

XX_____Signature of Patient or Legal Guardian

ATTENTION MEDICARE PATIENTS:

We will file your Medicare and supplements, but Medicare will only pay for services that it determines to be 'reasonable and necessary under section 1862(a)(l) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered is 'not reasonable and necessary' under Medicare program standards, Medicare will deny payment for that service. I believe that, ir *your* case, Medicare is likely to deny payment for a Complete Hearing Exam (CAE) , ABR, OAE, ENG (Balance) Testing, Tympanometry or Hearing Aid related for the following reasons: if the diagnosis is Sensorineural Hearing Loss, if th procedure/service is not paid separately or if deemed not reasonable and necessary by Medicare.

ALL CHARGES ARE DUE AT THE TIME OF SERVICE:

Please be prepared to pay your account at the time of each office visit or service delivery. All accounts are due and payable at th time of each service. *IF statements are sent on open accounts, the payment is due within 30 days from the date of services.* If the accoun is referred to an attorney or collection agency, the patient or responsible party hereby agrees to pay attorney's fees and the cost o collection.

Authorization for assignment of insurance claims and release of medical records is hereby given. *I understand that I an responsible for any amount not covered, or not approved, by insurance.* For Medicare patients, I have been notified by my Audiologist/Physician that he believes, that in my case, Medicare is likely to deny payment for the services identified above, i the reasons stated above apply. *I agree to be personally and fully responsible for payment.*

XX_____ Signature of Patient or Legal Guardian

Adult Hearing Health Assessment

Patient Name _____ Date _____ DOB _____

How did you find out about us?

☐ Yellow Pages ☐ Internet ☐ Referred by Patient _____

☐ Advertisement ☐ Insurance ☐ Referred by Physician _____

☐ Consumer Seminar ☐ Employer ☐ Other _____

What would you like to accomplish at today's appointment? _____

_____

When was your last hearing exam? _____ By whom? _____

How long ago did you notice a decline in your hearing? ☐ Within 1 Year ☐ 1–5 Years ☐ 6–10 Years ☐ 10+ Years

Have you ever utilized hearing devices? ☐ Yes ☐ No If yes, describe your satisfaction _____

_____

Which ear do you most often use on the telephone? ☐ R ☐ L ☐ Both ☐ Neither

Have you experienced a sudden or progressive hearing loss in the last 90 days? ☐ R ☐ L ☐ Both ☐ Neither

Have you ever had ear surgery? ☐ Yes ☐ No If yes, when: _____ Which ear: _____ Name of procedure: _____

Do you suffer from pain or discomfort in your ears? ☐ Yes ☐ No

Have you had chronic ear infections? ☐ Yes ☐ No

Do your ears produce significant wax? ☐ Yes ☐ No

Have you had any trauma to the head? ☐ Yes ☐ No

Are you experiencing any pressure in your ears? ☐ Yes ☐ No

Do you suffer from dizziness? ☐ Yes ☐ No

Do you suffer from tinnitus (ringing in the ears)? ☐ Yes ☐ No

Any family history of hearing loss? ☐ Yes ☐ No

Are you currently using any medications? ☐ Yes ☐ No

If yes, please list medications, dosage & how it' s taken

_____

Do you have a history of any of the following? ☐ Measles ☐ Mumps ☐ Diabetes ☐ Pneumonia

☐ Frequent Headaches ☐ High Fevers ☐ Meningitis ☐ Other (describe) _____

Have you been exposed to excessive noise levels without hearing protection in any of the following situations?

☐ Workplace ☐ Military ☐ Firearms ☐ Music ☐ Motorcycles ☐ Lawn Mower ☐ Other (describe) _____

Patient dexterity ☐ Good ☐ Fair ☐ Poor Patient vision ☐ Good ☐ Fair ☐ Poor

Please check all medical symptoms that apply:

_____ High Blood Pressure

_____ Nose, Throat, or Mouth Problems

_____ Cardiovascular Problems

_____ Musculoskeletal Symptoms (such as joint pain, swelling, recent trauma)

_____ Neurologic Symptoms (such as numbness, headaches, seizures, muscle weakness)

_____ Psychiatric Issues (such as depression, anxiety, compulsions)

_____ Kidney Problems

_____ Hematologic/Lymphatic Symptoms (such as bleeding gums, bruising)

_____ Allergic/Immunologic Symptoms (such as hives, asthma, itching, immune deficiency)

_____ Smoke / If so, how often? _____ Did you quit over 1 year ago? Yes / No

_____ Exposed to Second Hand Smoke

_____ Alcohol ____ Daily ____ Weekly ____ Occasionally

_____ Caffeine

_____ Stroke

_____ Cancer

_____ Have you fallen within the past year? If so, how many times? _____ With injury? _____

Does a hearing problem cause you to feel embarrassed when you meet new people?
Yes Sometimes No

Does a hearing problem cause you to feel frustrated when talking to members of your family?
Yes Sometimes No

Do you have difficulty when someone speaks in a whisper?
Yes Sometimes No

Do you feel handicapped by a hearing problem?
Yes Sometimes No

Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?
Yes Sometimes No

Does a hearing problem cause you to attend religious services less often than you would like?
Yes Sometimes No

Does a hearing problem cause you to have arguments with family members?
Yes Sometimes No

Does a hearing problem cause you difficulty when listening to TV or radio?
Yes Sometimes No

Do you feel that any difficulty with your hearing limits or hampers your personal or social life?
Yes Sometimes No

Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?
Yes Sometimes No

Are you experiencing or concerned about memory loss or brain health? Yes No

Are you interested or concerned about how your cognitive ability impacts your sports or work performance? Yes No

Did you know that improved hearing may positively impact memory and brain health? Yes No

Please check off all boxes where you would like to hear better

- ☐ Quiet Conversation
- ☐ Doorbell
- ☐ Phone Ringing
- ☐ Alarms (Clock, Security, Timers, etc.)
- ☐ Home Telephone
- ☐ Driving
- ☐ Religious Services
- ☐ Adult Conversations
- ☐ Small Family Gatherings
- ☐ Quiet Restaurants
- ☐ Cellphones
- ☐ Shopping
- ☐ Movie Theaters
- ☐ Health Clubs
- ☐ Small Group Meetings
- ☐ Conversations with Children
- ☐ Television
- ☐ Open/Reverberant Home
- ☐ iPod®/Personal Music Players
- ☐ Outdoor Activities
- ☐ Entertainment Venues (Casinos, Exhibit Halls, etc.)
- ☐ Busy Restaurants
- ☐ Frequent Social Gatherings
- ☐ Smartphones
- ☐ Conference Calls
- ☐ Multimedia Connectivity (Home Theater, Computer, Phone, etc.)
- ☐ Travel & Airports
- ☐ Concerts & Arts
- ☐ Group Presentations

Desired lifestyle? ☐ Private ☐ Quiet ☐ Active ☐ Dynamic

What are the top three environments in which you would like to hear better? **Does the companion agree?** ☐ Yes ☐ No

1. _____ _____ ____ ____
2. _____ _____ ____ ____
3. _____ _____ ____ ____

Please add any additional information here:

_____

_____

_____

_____

_____

_____

Electronic Mail and FAX Authorization

Email address:

request and authorize and its staff, to communicate with me and other authorized health care providers involved in my care about any aspect of my health and medical care by means of electronic mail or Faximile:

- I understand electronic mail is not appropriate for communication about all health issues, particularly those of an urgent nature and can make no guarantee of response within a certain time frame.

- I understand that electronic mail is not encrypted and therefore not as confidential as mail or telephone communication.

- I understand that it is possible for a third party, including an employer, to intercept or read electronic mail without knowledge of either the sender or recipient of the mail. Because of the ease and informality with which electronic mail can be used and because electronic mail may be easily rebroadcast to multiple addresses, the potential loss of confidentiality associated with its use may be of greater consequence than that suffered with written or telephone communication.

- Since does not operate or control any service on the internet, I understand cannot and does not guarantee that use of this means of communication will be free from technological difficulties including, but not limited to, loss of message.

- I understand that information communicated by means of electronic mail will be incorporated and retained within my medical record. As a result, that information including, but not limited to my electronic mail address, may be disseminated as part of an authorized release of a copy of the medical record.

My signature below denotes that I accept the risk of loss of privacy of confidential medical information associated with communication by electronic mail and nonetheless, agree to its use. I also agree that shall not be liable for any type of damage or liability arising from or associated with loss of confidentiality due to communication by electronic mail or faxing.

Signed By Patient, Parent, Guardian, or Authorized Representative _____ Date _____

My signature below denotes that I do not wish to receive any Private Health Information Documents through electronic mail.

Signed By Patient, Parent, Guardian, or Authorized Representative _____ Date _____

Please Note: Questions concerning the appropriateness of communication by means of electronic mail and Faxing should be resolved prior to signing above.

Acknowledgement of Receipt of Notice

ACI Hearing & Balance Center, Inc.

103 Saint Thomas St.
Lafayette, LA 70506

Kimberly Allred

337-235-6601

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Signed: _____ Date: _____ Print Name:_____

If not signed by the patient, please indicate.

Relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: _____

Yes No (circle one) I would like to receive a copy of any *amended* Notice of Privacy Practices by e-mail at: _____.

Where can we contact you? Please check all that may apply:

__**Work phone:** _____
__*Leave a detailed message*
__*Leave only our name and number*

__**Home phone:** _____
__*Leave a detailed message*
__*Leave only our name and number*

__**Cell phone:** _____
__*Leave a detailed message*
__*Leave only our name and number*

__**Other phone:** _____
__*Leave a detailed message*
__*Leave only our name and number*

Please list, in detail, any and all friends or family members who are authorized to discuss your personal health information.

Name:	*Date of Birth:*	*Relation to you:*
_____	_____	_____
_____	_____	_____

_____

For Office Use Only:

- ☐ Signed form received by: _____
- ☐ Acknowledgment refused:

Efforts to obtain: _____

Reasons for refusal: _____