ACI Hearing & Balance Center, Inc.
An Audio- Vestibular Laboratory
103 Saint Thomas Street
Lafayette, LA 70506
Ph: (337) 235-6601 • Fax: (337) 232-0772
E-mail: acihearing@cox-intemet.com
www.acihearing.com

Kimberly (Peezie) L. Allred, Au. D., FAAA, CCC-A-Owne
Elizabeth LeMaire, Au.D., FAAA
Sarah Lalande, Au.D.
Kristin Schoenfeld, Au.D.
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 amplificatioı 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, iı *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

Comprehensive PEDIATRIC Case History Form

Name: ___________________________________ Date:______________ Date of Birth: ______________ M / F

Did your pediatrician or other physician refer you here? YES NO (circle one)

If YES, when was the last time the child was examined by the physician?_________________________

Audiologic History

Does your child experience hearing loss? Yes No If so, which ear? Right Left Both

If you suspect hearing loss, which best describes it? Gradual Fluctuating Sudden

When did you first notice your child's hearing loss?: ____

What do you think is the cause of the hearing loss?: ____

Has your child ever had a hearing test? Yes No If so, when? ________ __________________________

Passed / Failed new born hearing screening? ________________ Name of the hospital ______________________

Please check all medical conditions that apply:

_____ Developmental Disorders/Delays: Explain ____

_____ Dizziness or Unsteadiness

_____ Ear Deformity: Right ear Left ear Both ears

_____ Ear Drainage: Right ear Left ear Both ears

_____ Ear Pain: Right ear Left Ear Both ears

_____ Family History of Hearing Loss: Who? ____

_____ History of Ear Infections Right ear Left ear Both ears Last infection: _____________

_____ History of Ear Wax Buildup

_____ History of Noise Exposure: Describe: ____

_____ Previous Ear Surgery Right ear Left ear Both ears When?_________________________

_____ Tinnitus/Ringing/Noises in ears: Right ear Left ear Both ears Frequency?_________

_____ Speech Disorder / Delay

_____ Failed Previous Hearing Examination

Other: Please describe:____

Pregnancy Information

Was the pregnancy full term? YES NO If NO, how early was the delivery?________________________

Did the baby require oxygen at birth? YES NO

Was the baby Jaundiced? YES NO If YES, did treatment require a blood transfusion? YES NO

Were there any other problems noted at birth? YES NO

If yes, What problems? ____

____

Please list any medication taken during the pregnancy: ____

____

Medical History

Any other illnesses, surgeries, injuries or hospitalizations since birth and their date(s) of occurrence: ____

____

Allergies (food, medications, plastics, etc.): ____

Has the PATIENT experienced any of the following major medical conditions (please check all that apply)

_____ AIDS/HIV
_____Kidney Problems
_____High Blood Pressure
_____Mumps
_____Encephalitis
_____High Fevers
_____Scarlet Fever
_____ Measles
_____Influenza
_____Stroke
_____Blood Disorders
_____Genetic Disorders
_____ Meningitis
_____ Heart Problems
_____ Vascular Problems
_____ Diabetes
_____ Head Injury
_____ Chicken Pox
_____ Typhoid
_____ Malaria
_____ Cancer
_____Tonsillitis
_____ Headaches
_____ Exposed to second hand smoke
_____ Other: ____

Current Medications (over the counter and prescriptions): ____________________________________

____

____

____

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: ____

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.