



Appointment Date: ____/____/____

Patient's Full Name: _____

Male: Female:

Address: _____ Apt: _____

Date of Birth: ____/____/____

City: _____ State: ____ Zip Code: _____

Phone1: (____) _____ - _____

Email: _____

Phone2: (____) _____ - _____

Which Physician referred you to us? _____

Or by what means did you hear of Audio Help? (Mailer, Ad, Website) _____

Check the circles below that apply to your current hearing ability, with equipment, if any.

Listening Environments	Well	Fair	Poor
One-to-One Conversations	i	i	i
Quiet Room (1-2 people)	i	i	i
Small Groups (4-6 people)	i	i	i
Large Social Gatherings	i	i	i
At the Work Place	i	i	i
Meetings/Lectures	i	i	i
Outdoors	i	i	i
Watching Television	i	i	i
On the Telephone	i	i	i

Please number the following in terms of their importance in a hearing aid. (1 being the most important):

Overall Sound Quality Reliability Style/Appearance Cost

What is your current status as a hearing aid user? (Check all that apply)

- I have never inquired about hearing aids.
- I have inquired about hearing aids, but have never worn or tried to purchase hearing aids.
- I have tried on a hearing aid, but did not purchase the hearing aid, or returned the aid.
- I have purchased a hearing aid, but I only wear it occasionally or not at all
- I have a hearing aid and wear it regularly on the Right Ear Left Ear

On a scale of 1-10, how motivated are you regarding doing something about your hearing loss?
(Please Circle)

1 2 3 4 5 6 7 8 9 10
Not Somewhat Moderately Very Extremely



Patient Name: _____

1st Insurance Company: _____

2nd Insurance Company: _____

Primary Insured: _____

Date of Birth: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Primary Physician: _____

Physician's Specialty: _____

Send a report to Physician? Yes No

Send a report to Patient? Yes No

COPAY DUE AT TIME OF SERVICE

Insurance ID: _____

Insurance ID: _____

Relationship: _____

Male Female

Home Phone: (____) _____ - _____

Employer: _____

Phone Number: (____) _____ - _____

Fax Number: (____) _____ - _____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

- Conduct, plan and direct my treatment and follow-ups among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

___ I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

___ I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

Signature: _____ Date: _____

ASSIGNMENT OF PAYMENT

I hereby authorize any payments issued by my insurance company (otherwise payable to me) to be mailed directly to Audio Help Associates. I understand that I am fully responsible for any charges not covered by my insurance company.

Signature: _____ Date: _____