Hearing Systems

PATIENT INFORMATION

Date: _____

Patient Name: _____ **DOB:** _____

Address: _____

City _____ **State** _____ **Zip Code** _____

Email address: _____

Telephone: Home: _____

Cell: _____

Work: _____

Emergency Contact -

Name: _____ **Phone #:** _____

Primary Care Physician: _____

Primary Insurance: _____

Secondary Insurance: _____

How did you hear about us?

- ☐ Established patient
- ☐ Walk-in
- ☐ Physician (please specify)
- ☐ Friend
- ☐ TV, Radio, Newspaper, Yellow Pages
- ☐ Mail
- ☐ Website Online Search
- ☐ Another Audiologist
- ☐ Insurance
- ☐ In-service at Senior Living
- ☐ 3rd Party

16103 West Little York Road, Suite F, Houston, TX 77084 (P)281-855-8916 (F)281-855-9193
Email: hearingsystemshouston@gmail.com Website: hearingsystemsinc.com

HEARING SYSTEMS
HIPPA PRIVACY NOTICE

We understand that medical information about you and your health is personal. We are committed to protecting the confidentiality of your medical information. As part of our routine operations, we create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements.

Federal law requires us to 1) make sure that medical information that identifies you is kept private, 2) give you the notice of our legal duties and privacy practices, and 3) follow the terms of the notice that is currently in effect.

If the practices described in this notice meet your expectations, there is nothing you need to do. If you have any questions regarding this Privacy Notice, please contact our Privacy Officer, Dr. Gemma Wall @ 281-507-7886.

All employees of our company follow the terms of this notice. Some employees may share medical information with each other for the purposes of treatment, payment or healthcare operations as described by this notice.

HOW WE MAY USE & DISCLOSE MEDICAL INFORMATION ABOUT YOU

For Treatment- We may use medical information about you to provide you with products or services. We may disclose medical information about you to other employees in order to coordinate the different products and services and we offer, such as lab personnel who may build and or repair your hearing aid. We may also disclose medical information about you to people outside the facility who may be involved in your medical care, such as family members or others we use to provide services that are part of your care.

For Payment- We may use and disclose medical information about you so that treatment, product and services you received for us may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your insurance company information about hearing aids you received from our company so your health plan will pay us or reimburse you for the products. We may also tell your health plan about a treatment or product you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations- We may use and disclose medical information about our facility operations. These uses and disclosures are necessary to run the facility and make sure that all of our clients receive quality care. For example, we may use medical information from a number of clients to review our products and services to see if we need to make changes, or to evaluate the performance of your staff in caring for you.

Appointment Reminders- We may use and disclose medical information to contact you as a reminder that you have an appointment at our facility.

Treatment Alternatives- We may use and disclose medical information to tell you about or recommend products or services that may be of interest to you.

Health-Related Benefits and Services- We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care- We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care.

As Required By **Law**- We will disclose medical information about you when required to do so by federal state or local law. We may also release medical information if asked to do so by law enforcement officials such as in response to a court order or subpoena.

Health Oversight Activities- We may disclose medical information to a health oversight agency or activities authorized by law. For example, we may disclose information to the Texas Department of Health relating to an audit for licensure.

Your Right Regarding Medical Information About You- You have the following rights regarding medical information we maintain about you. To exercise any of these rights, you submit the request in writing to: Hearing Systems, Attn: Gemma Wall, Au.D., 16103 West Little York Rd., Ste. F, Houston, TX 77084.

Right to Inspect and Copy- You have the right to inspect and obtain a copy of medical information that may be used to make decisions about your care. If you request a copy of the information, we may charge a fee of $10.00- for the costs of copying, mailing and administration.

Right to Amend- If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. As part of your written request to amend, you must provide a reason that supports your request.

*We may deny your request for an amendment of it is not in writing or does not include a reason to support *the* request. We may also deny your request if you ask us to amend information that: was not created by us, is not part of the medical information kept by our facility, is not part of the information which you would be permitted to inspect a copy, or if you ask us to amend information that is accurate and complete.

Right to an Accounting of Disclosures- This is a list of the disclosures we made of medical information about you. Your request must state a time period and way not include dates before February 01, 2006. The first list your request in a 12-month period will be free.
For additional lists, we may charge you for the costs of providing the list. We will notify you of the costs involved and you may choose to withdraw or modify you request before any costs are incurred.

Right to Request Restrictions- You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations. You also have the right or request a limit on the medical information we disclose about you to someone who is involved in your care, like a family member or friend. Written request for restrictions must tell us
1) what information you want to limit; 2) whether you want to limit our use, disclosure or both; and 3) to whom you want the limits to apply. *WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST.

Right to Request Confidential Communications- You have the right to request that we communicate with you about medical matters in a certain way or at certain locations, such as to contact you at home and not at work. Written requests for confidential communications must specify how or where you wish to be contacted. We will not ask you the reason for your request. We will accommodate all reasonable requests.

Changes to this Notice- We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information. We already have as well as any information we receive in the future. We will post a current copy of the notice in the facility.

Complaints- If you believe your privacy rights have been violated, you may file a complaint with Hearing Systems or with the Secretary of the Department of Health and Human Services. To file a complaint with our company, submit your complaint in writing to: Hearing Systems, Attn: Gemma Wall, Au.D., 16103 West Little York Rd., Houston, TX 77084 or State Board Of Examiners For Speech-Language Pathology and Audiology; Patrice Kennemer, Customer Service Coordinator, PO Box 149347, MC-1913, Austin, Texas 78714-9347.

Acknowledgement- We may ask you to acknowledge your receipt of this Privacy Notice. Should you decline to acknowledge receipt of this notice, we way record in your medical records the date the notice was given to you.

I **ACKNOWLEDGE THE** RECEIPT OF THIS PRIVACY NOTICE ON THIS **DATE** _____.

Option 1

I AUTHORIZE_____ TO RECEIVE COPIES OF MY RECORDS.

Initials

—OR—

Option 2

I WISH TO **KEEP MY** MEDICAL RECORDS **COMPLETELY CONFIDENTIAL FROM EVERYONE.**

Initials

_____

Signature

Hearing Systems

HEARING HANDICAP INVENTORY FOR ADULTS (HHIA)

Name: _____ Date: _____

INSTRUCTIONS: The purpose of the scale is to identify the problems your hearing loss may be causing you. Check YES, SOMETIMES, or NO for each question. DO NOT skip a question if you avoid a situation because of your hearing problem. If you use a hearing aid, please answer the way you hear WITHOUT **your aid.**

	Yes (4)	Sometimes (2)	No (0)
Does a hearing problem cause you to use the phone less often than you would like?			
Does a hearing problem cause you to feel embarrassed when meeting new people?			
Does a hearing problem cause you to avoid groups of people?			
Does a hearing problem make you irritable?			
Does a hearing problem cause you to feel frustrated when talking to members of your family?			
Does a hearing problem cause you difficulty when attending a party?			
Does a hearing problem cause you difficulty hearing/understanding coworkers, clients, or customers?			
Do you feel handicapped by a hearing problem?			
Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?			
Does a hearing problem cause you to feel frustrated when talking to coworkers, clients or customers?			
Does a hearing problem cause you difficulty in the movies or theater?			
Does a hearing problem cause you to be nervous?			
Does a hearing problem cause you to visit friends, relatives, or neighbors less often than you would like?			
Does a hearing problem cause you to have arguments with family members?			
Does a hearing problem cause you difficulty when listening to TV or radio?			
Does a hearing problem cause you to go shopping less often than you would like?			
Does any problem or difficulty with your hearing upset you at all?			
Does a hearing problem cause you to want to be by yourself?			
TOTAL=	_____	_____	_____

0-16% = No handicap **18-42% = Mild-Moderate Handicap** **44%+ = Significant Handicap**

16103 West Little York Road, Suite F, Houston, TX 77084 (P) 281-855-8916 (F) 281-855-9193
Email: hearingsystems@att.net Website: hearingsystemsinc.com

Hearing Systems

ADULT MEDICAL HISTORY

1. Chief complaint: □Hearing Loss (□Left Ear/□Right Ear) □Tinnitus/Ringing □Dizziness
   □Difficulty Hearing (□In Quiet □In Noise □Telephone -- □Right Ear □Left Ear)
2. Have you ever had your hearing tested? □Yes □No
   If yes, please give date: _____ By Whom? _____
3. Have you ever had surgery that may have affected your hearing? □Yes □No
   If yes, what type? _____ By Whom? _____
4. Have you seen an Ear, Nose and Throat Physician (ENT)? □Yes □No
   If so, who did you see? _____ When? _____
5. Have you ever had an ear infection? □Yes □No (If yes, □as a child □as an adult)
6. Have you ever had a serious illness that may affect your hearing?
   □Yes □No (i.e., Scarlet Fever, Meningitis, Mumps, etc.)
7. Do you take medications every day? □Yes □No Briefly describe for what condition?
   _____
   Please supply a copy of a list of multiple medications you might be taking.
8. Do you take Aspirin or any blood thinner's? □Yes □No
   (If yes, name of medication _____ , How often do you take it? _____)
9. Do you have any other medical conditions that may affect your hearing? □Yes □No
   If yes, please briefly explain:
   _____
10. Is there a history of hearing loss in your family? □Yes □No
    If so, who? _____
11. Please check any of the following that you currently have or have had in the past:
    □Arthritis □Heart Trouble □Measles □Parkinson's □Asthma □Hepatitis
    □Meningitis □Bell's Palsy □High Blood Pressure □Sinusitis □Diabetes
    □Visual Trouble-Loss/Sight □Neurological Symptoms □Head Injury □HIV
12. Have you, in the past 10 years, experienced chronic or acute dizziness, lightheadedness, or vertigo?
    □Yes □No If yes, please describe: _____
13. Have you seen a doctor for wax removal? □Yes □No
14. Do you have drainage of the ear? □Yes □No
15. Are you experiencing pain in your ear? □Yes □No
16. Do you think your hearing is changing? □Yes □No (□Gradual □Sudden)
17. Is this problem due to a work-related injury/exposure? □ Yes □No
18. How long have you had difficulty in communicating? _____
19. Have you ever been exposed to loud noise, either recently or in the past? (i.e., farm equipment, power tools, lawn mowers, chain saws, fire arms, military, etc.) □Yes □No
    If yes, was hearing protection used? □Yes □No or □Sometimes
20. Do you now or have ever worn hearing aids? □Yes □No
    Which ear is/was aided? □Right □Left
    Type of hearing aid? _____
    How long have you used a hearing aid? _____
    What would improve your current hearing aid? _____
21. Please rank the following in order of importance (1-4), if a hearing aid is recommended for you:
    _____Improve hearing in quiet environments _____improve hearing in noisy environments
    _____Cosmetic appearance _____ Expense