Ascent
AUDIOLOGY & HEARING
Patient Registration Form

Patient Name: ______________________ **Today's Date:** ____________

Street Address, City, State, Zip Code: ______________________

Guarantor/Responsible Party/Name of Insured (if different than above): ______________________

Social Security Number of Responsible Party/Insured: ______________________

Date of Birth of Responsible Party/Insured: ____________

Address of Guarantor, if different: ______________________

Home Phone: ____________ **Work Phone:** ____________ **Cell Phone #:** ____________

E-mail Address: ______________________ **Spoken Language:** English Spanish Other

Date of Birth: ____________ **Social Security Number:** ____________ **Gender:** Male or Female

Marital Status: Single Married Separated Divorced Widowed **Name of Spouse, if applicable:** ____________

If child, please list the name of the custodial parent/guardian: ______________________

Employer: ______________________ Part-Time Full-Time Retired

Occupation: ______________________

Emergency Contact: ____________ **Relationship to Patient:** ____________ **Phone #:** ____________

Referring Physician Name: ______________________ **Phone #:** ____________

Primary Care Physician Name: ______________________ **Phone #:** ____________

Would you like us to send a copy of your current and future test results and/or reports to (please check all that apply; by checking the box and listing below you are authorizing ASCENT AUDIOLOGY to communicate with these entities regarding your healthcare and treatment)):

- ☐ Referring Physician
- ☐ Primary Care Physician
- ☐ Other Physician: ______________________
- ☐ School: ______________________
- ☐ Family Member(s): ______________________
- ☐ Other: ______________________

How did you hear about us? (*Please check <u>all</u> that apply*):

_____ Phone book _____ Sign _____ Internet Search _____ Health Fair
_____ Family Member _____ Doctor _____ Direct Mail Piece _____ Open House
_____ Website _____ Friend _____ Newspaper _____ Facebook
_____ Other: ____________

WE WILL MAKE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD FOR OUR RECORDS.

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

Have you experienced any of the following major medical conditions:

_____ Bleeding Disorder	_____ Genetic Disorders	_____ High Blood Pressure	_____ Meningitis
_____ Cancer	_____ Head Injury	_____ Malaria	_____ Vascular Problems
_____ Diabetes	_____ Heart Problems	_____ Measles	_____ Other: __________

Current Medications (please list drug name, dosage, frequency and route into body):

Drug Name	Dosage (mg)	Frequency (how often)	Route (into body)

Please check all medical conditions that apply:

_____ Developmental disorder/delay — If checked, please explain: ____________________

_____ Dizziness or Unsteadiness — *If checked, is it accompanied by: Vomiting Nausea Ear Noises*

_____ Ear Deformity — *If checked, Right ear Left Ear Both ears*

_____ Ear Drainage — *If checked, Right ear Left Ear Both ears*

_____ Ear Pain — *If checked, Right ear Left Ear Both ears*

_____ Family History of Hearing Loss — *If checked, who?* ____________________

_____ History of Ear Infections — *If checked, Right ear Left Ear Both ears If so, when?* __________

_____ History of Falling — *If checked, have you fallen two of more times in the past year or been injured?* _____

_____ History of Noise Exposure — *If checked, please describe?* ____________________

_____ Previous Ear Surgery — *If checked, Right ear Left Ear Both ears If so, when?* __________

_____ Tinnitus/Ringing/Noises in ears — *If checked, Right ear Left Ear Both ears Frequency?* __________

_____ Tobacco Use — *If checked, what type of tobacco products?* ____________________

_____ (initial here) By initialing this section and signing below, I agree to allow ASCENT AUDIOLOGY to provide me with evaluation and treatment services. I understand that I may revoke this authorization at any time.

_____ (initial here) By initialing this section and signing below, I acknowledge that I received a copy of the ASCENT AUDIOLOGY Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be available in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available upon request.

_____ (initial here) By initialing this section and signing below, I authorize ASCENT AUDIOLOGY to send me educational and/or marketing information on the products and services offered by ASCENT AUDIOLOGY. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

_____ (initial here) By initialing this section and signing below, I agree to accept the financial policies of ASCENT AUDIOLOGY. I understand that payment in full is due on the date of service, including all co-pays, co-insurance, deductibles, and payment for non-covered services.

Signature of Patient or Guardian: ____________________ Date: ____________________

Adult Case History Form

Patient Name: ______________________ **Date of Completion:** __________

Date of Birth: ______________ **Gender:** ____________ **Primary Language:** ____________

Have you experienced any of the following major medical conditions (please check all that apply):

- ☐ AIDS/HIV
- ☐ Arthritis
- ☐ Blood Disorders
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Depression
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Encephalitis
- ☐ Fatigue
- ☐ Genetic Disorders
- ☐ Headaches
- ☐ Head Injury
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ High Fevers
- ☐ Influenza
- ☐ Malaise
- ☐ Malaria
- ☐ Measles
- ☐ Meningitis
- ☐ Mumps
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ TMJ
- ☐ Typhoid
- ☐ Vascular Problems
- ☐ Other: ______________

Have you been immunized? Yes No

If yes, for what illnesses or diseases: ______________________________

Please check all medical symptoms or conditions that apply:

- **Eye problems (such as blurred or double vision, pain):** Yes No
- **Nose, throat, or mouth problems (such as trouble swallowing, nose bleeds, dental issues):** Yes No
- **Cardiovascular issues (such as hypertension, chest pain, swelling, palpitations):** Yes No
- **Respiratory issues (such as shortness of breath, cough, wheezing):** Yes No
- **Gastrointestinal issues (such as nausea, vomiting, weight changes, diarrhea, pain):** Yes No
- **Musculoskeletal issues (such as joint pain, swelling, recent trauma):** Yes No
- **Neurological symptoms (such as numbness, headaches, tingling, seizures, muscle weakness):** Yes No
- **Psychiatric issues (such as depression, anxiety, compulsions):** Yes No
- **Endocrine symptoms (such as frequent urination, hot flashes):** Yes No
- **Hematologic/lymphatic symptoms (such as bleeding gums, bruising, swollen glands):** Yes No
- **Allergic/immunologic symptoms (such as hives, asthma, itching, immune deficiency):** Yes No

Comments related to Review of Symptoms above:

Audiologic History

Do you experience hearing loss? Yes No

If so, which ear? Right Left Both

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

When did you first notice your hearing loss? ____________________

What do you think is the cause of your hearing loss? ____________________

Have you ever had a hearing test? Yes No

If so, when: ____________________

Which ear do you typically use to talk on the telephone: Right Left

Have you ever worn or tried a hearing aid or amplifier? Right ear Left ear Both ears

What type and/or style of hearing aid or amplifier: ____________________

Please describe your experience: ____________________

Hearing Handicap Screening (please select the most appropriate response):

- **Does a hearing problem cause you to feel embarrassed when meeting new people?**
  Yes No Sometimes
- **Does a hearing problem cause you to feel frustrated when talking to members of your family?**
  Yes No Sometimes
- **Do you have difficulty hearing when someone speaks in a whisper?**
  Yes No Sometimes
- **Do you feel handicapped by a hearing problem?**
  Yes No Sometimes
- **Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?**
  Yes No Sometimes
- **Does a hearing problem cause you to attend lectures or religious services less often than you would like?**
  Yes No Sometimes
- **Does a hearing problem cause you to have arguments with family members?**
  Yes No Sometimes
- **Does a hearing problem cause you difficulty when listening to TV or radio?**
  Yes No Sometimes
- **Do you feel that any difficulty with your hearing limits or hampers your personal or social life?**
  Yes No Sometimes
- **Does a hearing problem cause you difficulty when in a restaurant with relatives and friends?**
  Yes No Sometimes

Office and Financial Policies

Thank you for choosing ASCENT AUDIOLOGY for your hearing healthcare needs. We are committed to you and your improved hearing and balance. We also want your experience with us to be a positive and productive one. To that end, we want to take this opportunity to inform our patients and their families of our payment policies. This knowledge will help you be better prepared for your appointment.

ASCENT AUDIOLOGY is a participating provider with many insurance carriers in the area. We can assist you in determining whether or not we are a participating provider for your insurance plan.

Insurance coverage is an agreement between you and your insurance carrier. We, as healthcare providers, just execute that agreement for you. As a result, it is your responsibility to determine whether or not you have out of network benefits (if ASCENT AUDIOLOGY is not a participating provider in your insurance plan), if you require prior authorization or a referral prior to services being provided or if audiology services and/or hearing aids are covered through your plan. It is important to gather this information prior to your appointment with us. ASCENT AUDIOLOGY cannot submit a claim to any insurance carrier if we do not have all required orders, referrals, or prior authorizations on file. They cannot be obtained after the service is provided. If you are unsure of your coverage specifics, please bring your member benefits handbook with you to the appointment.

Insurance carriers do not cover, in full, all goods and services. While will verify coverage specifics with your insurance carrier as needed, please understand that these are NOT a guarantee of coverage or payment. There may be situations where your insurance carrier does not cover the specific good or service you are requesting. ASCENT AUDIOLOGY commits to providing quality, professional hearing healthcare to all its patients, regardless of their circumstance. When required and possible, we will work to offer an item or service that is within the limits of your insurance coverage.

It is very important that you inform us within 24 hours of your appointment if you need to cancel or reschedule. While we realize that emergencies do occur, ASCENT AUDIOLOGY reserves the right to charge a $25 cancellation fee for all no-show appointments or appointments cancelled with less than a 24 hour notice.

We understand that sometimes you may be running late to your appointment. Unfortunately, we have patients scheduled throughout the day and may not be able to see you if you arrive more than 15 minutes after your scheduled appointment time. We will try to accommodate you if time allows. Otherwise, we will need for you come back later in the day if a later appointment is available or reschedule to another date and time.

Payment in full is due at the time the services are provided. You are responsible to pay all out of pocket expenses, such as co-pays, co-insurance and deductibles on the date the service is provided. All hearing aid related charges must be paid on the date you take possession of the aid, accessory or supply. ASCENT AUDIOLOGY reserves the right to charge a $15 re-billing fee for every invoice sent requesting payment.

ASCENT AUDIOLOGY accepts payment in the form of cash, checks, American Express, Visa, MasterCard, and Discover. We also offer a third-party credit program through Care Credit. There will be a $30 fee for all bounced or returned checks.

It is also the policy of ASCENT AUDIOLOGY that we maintain a credit card number on file. This allows us to bill you for an outstanding balance that is not collected within 120 days of the date you were initially billed, while continuing to provide you with care. We will not bill any charge to your credit card without first informing you of this in writing. You then have the right to use an alternate form of payment if you so choose.

It is important that each patient accepts and meets their financial obligations to this practice. Otherwise, we will be unable to provide care to any of our patients. ASCENT AUDIOLOGY reserves the right, following 120 days of the initial invoice date, to forward all outstanding balances to either a third-party collection agency and/or small claims court. We also reserve the right to discontinue care or service to patients who have not met their financial obligations to us.