Welcome

AUGUSTA AUDIOLOGY ASSOCIATES, PC
AH Medical Office Building Suite 204
70 Medical Center Circle
Fishersville, VA 22939
(540)332-5790

Thank you for selecting us to be your health care provider.
To help us meet all of your needs, **please fill out this form completely in ink**.
If you have any questions or need assistance, please ask us and we will be happy to help.
The information on this form is **confidential.**

Patient Information

Today's Date: _____

Have you been seen in our office before? ☐ Yes ☐ No

How did you hear about us? ☐Direct Mail ☐Yellow Pages ☐Newspaper ☐Physician Referral ☐Online ☐Word of Mouth ☐ Self Referral ☐Other _____

Do you **reside in a NURSING CARE FACILITY?** ☐ Yes ☐ No If **yes, where?** _____

Name _____
Last First Middle (Maiden)

Preferred Name _____ **E-mail Address**_____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Widowed **Check Appropriate Box** ☐ Male ☐ Female

Social Security Number _____ **Date of Birth** _____ **Age** _____

Physical Address_____**City**_____**State**_____**Zip**_____

Mailing Address_____ **City**_____**State**_____**Zip**_____

Home Phone_____ **Cell Phone**_____ **Work Phone**_____

Patient's Employer_____

Employer Address_____ **City**_____**State**_____**Zip**_____

Family Physician_____ **Referring Physician (if any)** _____

Responsible Party **(If patient is the responsible party, please leave this section blank)**

Responsibly Party Name _____ **Relationship to Patient**_____

Date of Birth _____ **Social Security Number** _____

Physical Address_____**City**_____**State**_____**Zip**_____

Home Phone _____ **Cell Phone** _____

Name of Employer _____ **Work Phone** _____

Employer Address_____ **City**_____**State**_____**Zip**_____

Insurance Information

□ AETNA □ ANTHEM □ HUMANA □ MEDICAID □ MEDICARE □ MEDICARE ADVANTAGE
□ OPTIMA □ TRICARE □ VIRGINIA PREMIER □ OTHER INSURANCE_____

Subscriber Name _____ **Relationship to Patient**_____

Date of Birth _____ **Social Security**_____

Physical Address_____**City**_____**State**_____**Zip**_____

Name of Employer _____ **Work Phone** _____

Employer Address_____ **City**_____**State**_____**Zip**_____

Payment For Services Policy

I request that payment of authorized insurance benefits be made on my behalf to Augusta Audiology Associates, PC for any services furnished to me by the audiologist/supplier. I authorize any holder of medical information about me to release to the insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. I agree to pay in full for services not covered by my insurance and for my portion of covered services including any legal or other costs incurred in the collection of this account, if it becomes delinquent. If I file my own claim, I agree to pay the full charge at the time of service. Augusta Audiology Associates will provide me with a monthly statement of my account. If I pay with a bank card a service charge of 3% will be deducted from any refunds.

Signature of Insured, Parent or Guardian (Seal)_____**Date**_____

Augusta Audiology Associates
70 Medical Center Circle
AH Medical Office Building, Suite 204
Fishersville, VA 22939
TELEPHONE: 540-332-5790 FAX: 540-332-5792

CONSENT TO RELEASE INFORMATION

NOTE: We will not release any information unless you have filled out and signed the authorization printed below:

Patient's Name:_____ **Birthdate:**_____ **Date:** _____

Authorization is given to Augusta Audiology Associates, P.C. to release or disclose information to the person or agency listed below.

The following information is requested for the purpose of **continuity of care.** Please release the selected specified information or reports:

☐ **All Records** ☐ **Hearing Evaluations Only** ☐ **Hearing Aid Records Only**

A copy of this Consent to Release Information will be as valid as the original.

1) **Person/Agency**_____ **Relationship** _____
Address/Phone_____
_____

2) **Person/Agency**_____ **Relationship** _____
Address/Phone_____
_____

3) **Person/Agency**_____ **Relationship** _____
Address/Phone_____
_____

4) **Person/Agency**_____ **Relationship** _____
Address/Phone_____
_____

☐ I give permission for Augusta Audiology Associates staff to add person(s) to this form <u>if my verbal consent is provided</u>.

☐ I **understand** this form and its meaning.
☐ I **requested assistance** with the meaning of this form from Augusta Audiology Associates staff and fully understand its meaning.

_____ _____
Signature of patient, parent, legal guardian, or POA Date Witness Date

AUGUSTA AUDIOLOGY ASSOCIATES, PC
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DECRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

With your consent, we may use individually protected health information about you for treatment (such as sending your medical record to a specialist physician as part of a referral), to obtain payment for treatment (such as sending billing information to a health insurance plan), and to evaluate the quality of care that you receive (such as comparing patient data to improve treatment methods).

Subject to certain requirements, we may give out information with your authorization for public health purposes, workers' compensation purposes, and in emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. We may also contact you about appointment reminders or treatment alternatives.

In any other situation, we will ask for your written authorization before using or disclosing any information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization in writing to stop any future uses and disclosure.

In most cases you have the right to review or receive a copy of information about you that we use to make decisions about you. You must understand that we have 15 days from your written request to schedule an appointment to meet with you. If you request copies, we will charge $0.50 per page plus all postage and shipping costs. If you believe that information in your record is incorrect or if important information is missing, you have the right to request, in writing, that we correct the existing information. You may request in writing that we not use or disclose your information for treatment or to persons involved in your care except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but we are not legally required to accept it.

If you are concerned that we have violated your privacy rights, you may contact the person listed below. You may also send a written complaint to the attention of the Secretary of the U.S. Department of Health and Human Services.

We are required by law to protect the privacy of your information, provide this Notice about your information practices, and follow the information practices that are described in this Notice. **Future updates will be posted in the waiting area.**

Contact person: Julie Farrar-Hersch PhD, Audiologist/Owner
Augusta Audiology Associates, PC
70 Medical Center Circle, Suite 204
Fishersville, VA 22939
(540) 332-5790 or (540) 932-5790

I acknowledge that I have read this Notice of Privacy Practices from Augusta Audiology Associates.

Do you wish to receive a copy of this Notice? ☐ Yes ☐ No

May we leave a message on your voicemail? ☐ Yes ☐ No

_____ _____
Signature of Patient or Patient's Representative Date

Augusta Audiology Associates
Case History Form

Patient Name _____ **Date of Birth** _____ **Date** _____

Reason for Visit

_____

_____

Past Medical History (check if applicable)

☐Mumps	☐Diabetes	☐Head Injury: When? _____
☐Meniere's	☐Measles	☐Other (list all): _____
☐Pneumonia	☐Encephalitis	_____
☐Meningitis	☐High Blood Pressure	_____
☐Sinusitis	☐Memory Problems	_____
☐Allergies	☐Stroke: When?: _____	_____

Review of Symptoms (check if applicable):

☐Drainage.....	☐Right Ear	☐Left Ear	When did it start? _____
☐Pain or Discomfort.....	☐Right Ear	☐Left Ear	When did it start? _____
☐Ringing or Buzzing.....	☐Right Ear	☐Left Ear	When did it start? _____
☐Hearing Loss.....	☐Right Ear	☐Left Ear	When did it start? _____
☐Ear Surgeries.....	☐Right Ear	☐Left Ear	When and what type? _____

_____

_____

☐Dizziness Please describe symptoms and frequency of episodes. _____

_____

_____

Medications (Please list): _____

_____

_____

Hearing History

Where/who do you have **difficulty hearing**? **(check all that apply)**

☐Men	☐Women	☐Children
☐In Church	☐At Work	☐In Traffic
☐In Groups	☐In Quiet	☐In Noise
☐Television	☐Telephone	

Have you ever been **exposed to loud noise**? ☐Yes ☐No

If yes, **where**? ☐Home ☐Work ☐ Recreational

Please describe **type of noise**. _____

Do you **wear hearing protection** during loud noise exposure? ☐Yes ☐No

If yes, **what type** do you use? ☐Plugs (Foam/Flange) ☐Muffs ☐Custom ☐Other: _____

Do you have a **family history** of hearing loss?

☐Parent	☐Grandparent	☐Sibling
☐Aunt	☐Uncle	☐Cousin
☐Children	☐Unknown	

Hearing Aid History

Have you ever used hearing aids? ☐Yes ☐No

If yes, how long have you been wearing them? _____

How old are your current devices? _____

Comments regarding use of hearing aids _____

_____

_____