



Pathway Audiology

Patient Information

Demographics:

Patient Name _____ Date of Birth ____/____/____ Male Female

SSN: XXX-XX-_____ Home Phone (____) ____-____ Cell Phone (____) ____-____

Address _____ City _____ State ____ Zip _____

Marital Status: S M D W Spouse's Name _____

Primary Care Physician (Required**) _____ Phone (____) ____-____

Make/Model of Cell Phone _____ Preferred method of contact: Call Text Email

Emergency Contact:

Name _____ Phone (____) ____-____ Relation to Patient _____

How did you hear about us? Please circle all that apply and provide names where applicable.

Physician (specify) _____ Friend or Family Member (specify) _____

Mail Newspaper Website Google Facebook KBEST KBYG Other: _____

Employer:

Name of Business _____ Phone (____) ____-____ _____ Retired

Patient Portal:

Would you like us to activate your secure, online patient portal (to view reports, invoices, etc.)? **Yes No**

If yes, please provide your email _____

Do you authorize Pathway Audiology to send you educational emails about hearing loss, tinnitus, and hearing aids; promotional products; and/or clinic events? **Yes No**

Responsible Party Signature (Required**) _____ Date _____



Pathway Audiology

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your, or your dependent's, protected health information is used and disclosed for treatment, payment, or healthcare operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for use of the information for treatments, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

By signing this form, I understand that, unless indicated below, **Pathway Audiology, PLLC may call/leave a voicemail, text, or email to confirm appointments or relay important information regarding any appointments.**

_____ I **DO NOT** authorize Pathway Audiology to text or email appointment confirmations to the phone number or email I provided on the Patient Information form.

_____ I **DO NOT** authorize Pathway Audiology, PLLC to leave a voicemail with appointment information. Pathway Audiology, PLLC may still leave a voicemail asking me to call them back without leaving any additional information.

Please list any contacts that we are allowed to discuss or release records to (**please include yourself if filling out for your dependent**):

Name: _____ Relation: _____ Phone Number: (____) ____ - _____

Name: _____ Relation: _____ Phone Number: (____) ____ - _____

This consent was signed by: _____ (PLEASE PRINT)

Patient Signature

Date

Staff Signature

Date



Pathway Audiology

Patient Authorization

Clinical

1. I authorize Pathway Audiology, PLLC to perform all recommended/referred diagnostic procedures on myself or my dependent.
2. I authorize Pathway Audiology, PLLC to complete all measures needed to make a thorough diagnosis and recommendation. I authorize that such diagnostic material may be released to and/or obtained from third-party payors and/or other health professionals. This includes the primary care physician as listed on the Patient Information form, any physician who referred me or my dependent to Pathway Audiology, PLLC, and/or other healthcare professionals as specified on a medical release form, signed by me.

Financial

3. I authorize Pathway Audiology, PLLC to furnish all information regarding medical history, diagnosis, and treatment to my insurance company regarding a claim for benefits. If, however, said insurer fails to meet this obligation in whole or in part, or if I am non-insured, I agree to be responsible to the fee and cost involved in my treatment. I authorize payment of medical benefits to Pathway Audiology, PLLC and further understand that should my account have to be referred to a collection agency that I am responsible for all fees and costs incurred therein. I hereby authorize Pathway Audiology, PLLC to act on my behalf in accessing medical records when and if needed.

Insurance

4. I authorize Pathway Audiology, PLLC to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records and other diagnostic material about my medical history, services rendered, or recommended treatment. I authorize Pathway Audiology, PLLC to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company on my behalf and in my name listed as "signature on file".
5. I certify that I, and/or my dependents, have insurance coverage with the insurance company listed on the card that I provided today and assign directly to Pathway Audiology, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
6. The above named may use my healthcare information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient Signature

Date



Pathway Audiology

Hearing Handicap Inventory Screening for Adults

	NO	SOMETIMES	YES
Does a hearing problem cause you to feel embarrassed when you meet new people?			
Does a hearing problem cause you to feel frustrated when talking to members of your family?			
Do you have difficulty hearing/understanding co-workers, 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 difficulty in the movies or in the theatre?			
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?			
Do you feel that your hearing problem limits or hampers your personal or social life?			
Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?			

If we find your hearing challenges could be helped by hearing devices, would you be open to trying a solution? YES POSSIBLY NO

Please check hearing aid features you may be interested in:

____Invisibility ____Bluetooth/Smart Phone Streaming
____Rechargeability ____Cost-Effective ____Hearing in Noise



Adult Case History

Was there any specific circumstance that brought you in today? _____

Audiologic History:

1. Have you ever had ear surgery? Yes No

If yes, what kind of surgery? _____

2. Have you ever been evaluated by an Ear, Nose, and Throat (ENT) Physician? Yes No

If yes, name of ENT: _____

3. Do you experience pain or pressure in your ears? Yes No

4. Do you have a history of noise exposure? Yes No

If yes, describe: _____

5. Do you have noises in your ears (i.e., ringing, roaring)? Yes No

If yes, does it interfere with sleep? Yes No

6. Have you noticed dizziness? Yes No

If yes, please circle which best describes it: Spinning Lightheadedness Off Balance

7. Have you taken medication that may have affected your hearing? Yes No

If yes, what medication(s)? _____

8. Do you have concerns with memory loss? Yes No

9. Do you have issues with dexterity (fine motor skills in hands/fingers)? Yes No

10. Do you have difficulty hearing on your cell phone? Yes No

11. Do you currently wear hearing aids? Yes No

If yes, what brand (if known)? _____ How old are they? _____

Medical History: (Check/Circle all that apply)

☐ Brain Injury ☐ Stroke ☐ PTSD ☐ Pacemaker ☐ Diabetes

☐ Diagnosed with Alzheimer's/Dementia

☐ Use of Blood Thinner

Which one? Coumadin (Warfarin) Plavix Baby Aspirin Other: _____

☐ Chemotherapy/Cancer

What type(s) of Cancer? _____

☐ Other: _____

Anything else we should know? _____