

COVE AUDIOLOGY & HEARING SERVICES

130 FOREST AVENUE • GLEN COVE, NY 11542 • 516-759-0665

Joseph S. Monestere, BC-HIS, ACA
Audioprosthologist
Board Certified by the
National Board for Certification
in Hearing Instrument Sciences

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Board Certified Doctor of Audiology
American Speech-Language-Hearing Association

Lenore C. Monestere, MA, BC-HIS, ACA
Audioprosthologist
Board Certified by the
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CONFIDENTIAL PATIENT INFORMATION

Date: _____

Title: Dr. ☐ / Mr. ☐ / Mrs. ☐ / Ms. ☐ Name: _____
First MI Last

Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Age: _____ Gender: Male ☐ Female ☐ Other ☐
MM/DD/YYYY

Email Address: _____

Primary Insurance Company: _____ Policy Number: _____

Secondary Insurance Company: _____ Policy Number: _____

Marital Status: ☐ Single / ☐ Married / ☐ Divorced / ☐ Separated / ☐ Widowed / ☐ Domestic Partner

Employment Status: ☐ Full Time / ☐ Part Time / ☐ Unemployed / ☐ Retired / ☐ Student / ☐ Other

Current or prior occupation (please be specific): _____

Emergency Contact: _____ Relationship to Patient: _____
First Last

Emergency Contact's Phone Number: _____ (please specify: ☐ H / ☐ C / ☐ W)

Who referred you, or how did you find out about us? _____

Primary Care Physician: _____ Phone: _____
First Last

Address: _____
Street City State Zip Code

Date: _____

Title: Dr. ☐ / Mr. ☐ / Mrs. ☐ / Ms. ☐ Name: _____
First MI Last

CONSENT TO TREATMENT, ASSIGNMENT AND FINANCIAL AGREEMENT:

1. **Assignment, Release and Financial Agreement:** I authorize treatment of person named above by Cove Audiology and Hearing Services and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to Cove Audiology and Hearing Services, and I am financially responsible for non-covered services. **I further agree the account is to be paid in full at the time of service unless other arrangements have been made.** Should the account be referred to a collection agency or an attorney for collection, I will pay all reasonable collection agency, attorney fees and court costs. I also authorize the release of medical information to facilitate healthcare, processing of claims, and audit of payments.
2. **DISCLAIMER:** As a professional courtesy, Cove Audiology and Hearing Services will submit your claim to your insurance provider, but **this does not guarantee their payment.** You accept responsibility for any copays, deductibles, or uncovered procedures. If you have a hearing aid benefit, you may be required to pay for your hearing aid upfront. Upon receipt of payment from your insurance company, we will reimburse you for the amount that the insurance company covered/paid.
3. **ASSIGNMENT OF BENEFITS:** I hereby assign and transfer to Cove Audiology and Hearing Services sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my medical care of the care and treatment rendered to myself or my dependent in said practice. I understand I am responsible for any services not covered by my insurance. I accept responsibility for payment of my account.
4. **INSURANCE RELEASE:**
 - I authorize use of this form on all my insurance submissions.
 - I authorize release of information and my records to my insurance company(s) if requested.
 - I authorize Cove Audiology and Hearing Services to act as my agent in helping obtain payment from my insurance company(s).
 - I authorize payment directly to Cove Audiology and Hearing Services.
 - I permit a copy of this authorization to be used in place of the original.
5. For services related to motor vehicle accidents, workers' compensation, or legal claims, the patient **remains financially responsible for all charges** in the event payment is not received from the responsible third party.

PATIENT SIGNATURE: _____

DATE: _____

ADULT AUDIOLOGY INTAKE FORM

What prompted you to come in today? _____

Is your visit related to any of the following? (For billing and documentation purposes only)

Check all that apply:

- ☐ Motor vehicle accident (No-Fault)
- ☐ Workers' Compensation
- ☐ Personal injury claim / legal matter
- ☐ Veterans Affairs (VA) claim
- ☐ Other (please specify): _____
- ☐ None of the above

If applicable, is an attorney involved? ☐ YES ☐ NO

Have you ever had your hearing tested before? ☐ YES ☐ NO

If YES, when and where were you tested? _____

If YES, do you have a copy of any prior test results you can provide us with? ☐ YES ☐ NO

Do you experience hearing difficulty? ☐ YES ☐ NO ☐ NOT SURE

If YES, which ear(s)? ☐ RIGHT ☐ LEFT ☐ BOTH

If YES, how long have you experienced hearing difficulty? _____

If YES, is the change in your hearing: ☐ GRADUAL ☐ SUDDEN ☐ FLUCTUATING ☐ LONGSTANDING

If YES, do you know the cause of your hearing difficulty? _____

Do you currently wear amplification? ☐ YES ☐ NO

If YES, which ear(s)? ☐ RIGHT ☐ LEFT ☐ BOTH

If YES, are you satisfied with your current amplification? ☐ YES ☐ NO

If YES, how old are your current hearing devices? _____

If YES, where were you fit with your current hearing devices? _____

Have you been examined by your physician within the past 6 months? ☐ YES ☐ NO

Which ear is your better ear? ☐ RIGHT ☐ LEFT ☐ SAME ☐ NOT SURE

Is there a family history of hearing difficulty? ☐ YES ☐ NO ☐ NOT SURE

If YES, who? _____ If YES, did they wear hearing devices? ☐ YES ☐ NO

Do you have ANY history of noise exposure?

☐ YES ☐ NO

If YES, please check all that apply:

- ☐ Military service ☐ Construction / heavy machinery ☐ Engineering / industrial equipment
☐ Hunting / shooting ☐ Loud music / concerts ☐ Fitness studios / loud classes
☐ Power tools (leaf blowers, lawn mowers, chain saws, etc.)
☐ Other: _____

Did you wear hearing protection? ☐ YES ☐ NO ☐ SOMETIMES

Military service (if applicable):

Branch: _____ Service Dates: _____

Do you currently have tinnitus (ex. "ringing", "buzzing", "hissing", "whooshing")?

☐ YES ☐ NO

If YES, which ear? ☐ RIGHT ☐ LEFT ☐ BOTH

How would you describe it? (check all that apply)

- ☐ Constant ☐ Intermittent ☐ Pulsatile ☐ Sudden onset ☐ Gradual onset

When did it begin? _____

How bothersome is it?

- ☐ Mild ☐ Moderate ☐ Severe

Have you ever experienced dizziness, unsteadiness, imbalance and/or vertigo? ☐ YES ☐ NO

If YES:

How would you describe it? (check all that apply)

- ☐ Spinning sensation (vertigo) ☐ Lightheadedness ☐ Imbalance / unsteadiness ☐ Faint feeling

How often does it occur?

- ☐ Single episode ☐ Occasional ☐ Frequent ☐ Constant

Typical duration of each episode?

- ☐ Seconds ☐ Minutes ☐ Hours ☐ Days

Is it accompanied by any of the following? (check all that apply)

- ☐ Nausea ☐ Vomiting ☐ Ringing in the ears ☐ Hearing loss
☐ Ear fullness ☐ Visual disturbances ☐ Tingling ☐ Limb weakness
☐ Positional (triggered by head movement / rolling in bed) ☐ Other: _____

Are you experiencing these symptoms today? ☐ YES ☐ NO

If NO, when was your most recent episode? _____

Do you have a history of ear infections?

☐ YES ☐ NO

If YES, please explain: _____

Do you presently have active drainage from your ears? ☐ YES ☐ NO

If YES, which ear? ☐ RIGHT ☐ LEFT ☐ BOTH

Do you have a history of ear surgery? ☐ YES ☐ NO

If YES, which ear? ☐ RIGHT ☐ LEFT ☐ BOTH

If YES, please explain: _____

Do you presently have pressure and/or pain in your ears? ☐ YES ☐ NO

If YES, which ear? ☐ RIGHT ☐ LEFT ☐ BOTH

Do you experience visual difficulties or disturbances? ☐ YES ☐ NO

If YES, please elaborate: _____

Do you have difficulty handling small objects? ☐ YES ☐ NO ☐ SOMETIMES

If YES or SOMETIMES, please explain: _____

Have you fallen within the past 12 months? ☐ YES ☐ NO

If YES, how many falls have you experienced in the past 12 months? _____

If you have fallen, have you been injured? ☐ YES ☐ NO

- Please describe your injury: _____

Have you used any tobacco or cannabis products in the past 12 months?

☐ YES ☐ NO

If YES, what type(s) of products have you used? _____

If YES, how often have you used a tobacco or cannabis product in the past 12 months? _____

If YES, how many packs per day? _____ For how many years? _____

Do you consume alcohol? ☐ YES ☐ NO

If YES, on average, how many days a week do you have an alcoholic beverage? _____ days

If YES, on a typical drinking day, how many drinks do you have? _____ drinks

Have you ever undergone treatment for cancer (chemotherapy, radiation)? ☐ YES ☐ NO

If YES, please elaborate on type of cancer(s), stage of cancer(s), treatments received and duration/rounds of treatment: _____

Please list all medications that you are taking, prescription and/or over-the-counter, including herbal and vitamin supplements:

Medication	Reason	Dose	Frequency

Do you have a pacemaker? ☐ YES ☐ NO

Do you have a defibrillator? ☐ YES ☐ NO

Have you ever experienced any of the following medical conditions:

- | | | | |
|---|--|--|--|
| ☐ Diabetes Type I | ☐ Diabetes Type II | ☐ Cardiovascular disease | ☐ Meniere's Disease |
| ☐ High blood pressure | ☐ Low blood pressure | ☐ Memory or cognitive changes | |
| ☐ Alport Syndrome | ☐ Otosclerosis | ☐ Rheumatoid arthritis | ☐ Stroke/TIA |
| ☐ Osteoporosis | ☐ Chronic lung disease | ☐ Chronic kidney disease | ☐ High Cholesterol |
| ☐ Anxiety | ☐ Depression | ☐ AIDS/HIV | ☐ Head injury/trauma |
| ☐ Autoimmune disease | ☐ Excessing bleeding | ☐ Thyroid Disease | ☐ Chicken Pox |
| ☐ Macular degeneration | ☐ Measles | ☐ Mumps | ☐ Encephalitis |
| ☐ Meningitis | ☐ Tuberculosis | ☐ Double vision | ☐ Paget's Disease |
| ☐ Malaria | ☐ Difficulty swallowing | ☐ Numbness around face | ☐ Difficulty speaking |
| ☐ Migraine Headache | ☐ Hepatitis (A, B, C, D, E) | ☐ Von Recklinghausen NF | |
- ☐ Exposure to chemicals/drugs associated with hearing loss (please explain): _____

Please list all allergies (ex. food, medications, plastics, materials): _____

HEARING ASSESSMENT

Do you feel people are mumbling? ☐ YES ☐ NO ☐ SOMETIMES

Must others raise their voices? ☐ YES ☐ NO ☐ SOMETIMES

Do you find it difficult to hear in noisy places? ☐ YES ☐ NO ☐ SOMETIMES

Have you been told that you speak too loudly? ☐ YES ☐ NO ☐ SOMETIMES

Do you understand the conversation when someone is behind you? ☐ YES ☐ NO ☐ SOMETIMES

Do you have difficulty telling which direction sound is coming from? ☐ YES ☐ NO ☐ SOMETIMES

Do others complain that you set the TV or radio volume too loud? ☐ YES ☐ NO ☐ SOMETIMES

Have you been told that you've missed the ringing of the telephone? ☐ YES ☐ NO ☐ SOMETIMES

Do you have any difficulty understanding speech while on the telephone? ☐ YES ☐ NO ☐ SOMETIMES

Which ear do you use on the telephone? ☐ RIGHT ☐ LEFT ☐ BOTH

Do you avoid social events because of hearing difficulty? ☐ YES ☐ NO ☐ SOMETIMES

Do you have difficulty hearing at the movies or the theater? ☐ YES ☐ NO ☐ SOMETIMES

Please check the appropriate box which reflects your ability to hear in the situations listed and check how often you are in that situation:

LISTENING SITUATION	HOW OFTEN ARE YOU IN THIS SITUATION?			HOW WELL DO YOU HEAR IN THIS SITUATION?		
	RARELY	OFTEN	SOMETIMES	POOR	GOOD	FAIR
QUIET ROOM (1 - 2 PEOPLE)	☐	☐	☐	☐	☐	☐
RESTAURANTS	☐	☐	☐	☐	☐	☐
CAR	☐	☐	☐	☐	☐	☐
TELEVISION	☐	☐	☐	☐	☐	☐
CHURCH/MEETINGS/LECTURES	☐	☐	☐	☐	☐	☐
WORK PLACE	☐	☐	☐	☐	☐	☐
TELEPHONE	☐	☐	☐	☐	☐	☐
LARGE SOCIAL GATHERINGS	☐	☐	☐	☐	☐	☐

Name of person filling out these forms: _____ Relationship to patient: _____

Patient/Representative Signature: _____ Date signed: ____ / ____ / ____

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Consent for Use and Disclosure

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Hearing Healthcare Operations.

I, _____, understand that as part of my health care, Cove Audiology and Hearing Services originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Cove Audiology and Hearing Services is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Cove Audiology and Hearing Services reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Cove Audiology and Hearing Services change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, of health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I, _____, give Cove Audiology and Hearing Services permission to:

☐ _____ correspond with any member of my family;

☐ _____ correspond with my doctor or any other healthcare professional when medically necessary or if requested by me;

☐ _____ contact me to schedule an appointment or to confirm an appointment by leaving phone messages, or by mailing postcards and/or letters, and to notify me of warranty expirations;

☐ _____ send me copies of receipts

I fully understand and accept the terms of this consent.



Patient's Signature

Date

FOR INTERNAL OFFICE USE ONLY

Consent received by _____ on _____.

☐ Consent refused by patient, and treatment refused as permitted.

Consent added to the patients' medical record on _____.