Date: **HEARING & BALANCE Services of Reston:REGISTRATION**

NAME_____ **SS#** _ _ _ _ _ _ _ _ _ _ _

Email _____

ADDRESS_____

CITY_____ **STATE**_____**ZIP**_____

HOME PHONE_____ **CELL PH.** _____ **WORK PH.**_____
CONSENT TO TEXT MESSAGE: Yes____ No____ (Reminders & Alerts)
BIRTH DATE_____**AGE**_____**SEX: MALE**_____**FEMALE** ☐
MARITAL STATUS: Single___, Married___ Separated, ___ Divorced___, Widowed___
SPOUSE / NEAREST RELATIVE _____**PHONE**_____

FAMILY PHYSICIAN NAME: _____

HOW DID YOU HEAR ABOUT US? _____

MEDICAL HISTORY

Do you have any allergies? □ Yes □ No **Are you insulin dependent diabetic? □Yes □No**
Do you have arthritis? □Yes □ No **Are you currently taking medication? □Yes □No**
If yes, please list _____
_____

Have you received any medical or surgical treatment for hearing loss? □ Yes □ No
If yes, when? _____**Physician/ENT:**_____**Phone**_____

HEARING INSTRUMENT PRIORTIES

If you can be helped with hearing instruments list your priority order, write your preference in order of importance (1 = most important and 4 = least important)

☐ **Understanding speech better** ☐ **Size or appearance** ☐ **Cost** ☐ **Hearing in noisy surrounding**

HEARING INSTRUMENT EXPERIENCE

Have you worn hearing aids? Yes ☐ **No** ☐ **Left** ____**Right** _____ **Both** _____
Are you wearing hearing aids now? Yes ☐ **No** ☐ **Left** ____**Right** _____ **Both** _____

Make _____ **Style** _____ **Year Purchased** _____
Please describe your experience with your current hearing aids: _____
_____
_____

Medical Examination waiver: I have been advised by Bhama Pathak, MA, CCC-A, FAAA (dispenser) that my best health interest would be served if I had medical evaluation by a licensed physician, preferably by one who specializes in diseases of ear, before purchasing a hearing instrument. I do not wish to have such a medical evaluation done before purchasing the hearing instrument.
Bhama Pathak, MA, CCC-A, FAAA
Audiologist

_____
Signature of Patient or Guardian
Printed Name _____

PATIENT HISTORY: Hearing & Balance Services of Reston

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_____
Patient Name Date _____

_____
Companion Name

1. Who encouraged you to visit our clinic today? _____

2. What brings you in today?_____

_____

3. What have you noticed about your hearing/communication ability? _____

_____

_____

4. How long have you noticed any difficulties? _____

5. What have others noticed about your hearing/communication ability?_____

_____

6. Have you had your hearing tested before? Yes ☐ No ☐
If yes, by whom? _____Date:_____

7. Please check any of the following conditions that you have and add any comments you feel may help your audiologist understand and treat all of your hearing concerns.

Yes	No
☐	□ **Pain /discomfort in ears**
☐	□ **Noises in your ears**
☐	□ **History of hearing loss in your family**
☐	□ **Dizziness or balance problems**
☐	□ **Excessive noise exposure**
☐	□ **Surgery or medical problems with ears (drainage)**
☐	□ **Sudden hearing loss in the past 90 days**

8. What medications, if any, are you currently taking? _____

_____

9. Do you have any other medical conditions that we should be aware of? _____

_____

HIPPA DISCLOSURE
HEARING & BALANCE Services of Reston (Organization)

By signing this form, I understand that I am giving the above organization authorization to use or disclose the following information:

Specify information to be disclosed: **Contents of office records.**

Recipient: **Anyone related to my care or as permissible under revised HIPPA law.**

Right to Revoke: I understand that I may restrict the individuals or organizations to whom my healthcare information is released. Further, I understand that I may revoke my authorization at any time, however, my revocation must be in writing, mailed to the above organization at the office address listed below, and the organization must only comply with such revocation to the extent it is consistent with its Notice of Privacy Practices.

Re-disclosure: Information that the organization uses or discloses based on the authorization I am giving may be subject to re-disclosure by the person who receives the information and may no longer be protected by the Federal Privacy Rules.

Refusal: I have the right to refuse to give the above organization this authorization. If I do not give the authorization, it will not affect the treatment I receive or the method used to obtain reimbursement for my care, except however, if my treatment at the above organization is for the sole purpose of creating health information for disclosure to the recipient identified in this authorization, in which case, the above organization may refuse to treat me if I do not sign this authorization.

Inspect / Copy: I may inspect or copy the information that the above organization may send at any time.

Term: This notice is effective as of the date set forth below and will remain in effect until:

I provide written notice of revocation to the above organization. **The revocation will be effective immediately upon the organization's receipt of my written notice, except that the revocation will not have any effect on any action taken by the organization in reliance on this authorization before it received my written notice of revocation.**

Or the following date or event _____

Or the organization fulfills the request_____(check if applicable)

Purpose: I authorize the above organization to use or disclose my health information in manner described above to the recipient for the term for the following specific purpose**: At the request of patient or legal guardian.**

Contact: I may contact the organization's privacy officer by mail at:

Bhama Pathak, M.A., CCC-A, FAAA
1800 Town Center Drive, Suite 315
Reston, VA 20190
Phone: (703) 478-9898

I hereby acknowledge that I have received a copy of this authorization if requested. I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby knowingly and voluntarily authorize the above organization to use or disclose my health information in the manner described above.

Signature of Patient/Personal representative/Legal guardian Effective date

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Print Patient's Name Personal representative's authority

Print Name of Personal Representative

Refused to Sign: _____ Date: _____

Revised: September 24, 2021