GEORGE IWANOW HEARING AID CENTERS, INC.

We Listen - You Hear, Since 1954

Office: Livonia Macomb Royal Oak St. Clair Shores Wyandotte **Today's Date:**____/____/ 20____

First Name____ **Last Name**____ M F

Date of Birth____/____/____ **Your Age**____

Address____ **City**____ **State**___ **Zip**____

Home Phone: (____)____-____ **Cell:** (____)____-____ **Email:**____

Whom are you with for your apoointment today?____ **Relation**____

____ **Relation**____

Emergency Contact:____ **Phone:** (____)____-____

How did you hear about us?____

Do any of your close relatives have/had a hearing problem?____

When did you notice your hearing problems?____

When did you have your last hearing test?____ **Where?**____ **Results**____

Did you purchase hearing aids?____ **If yes, where?**____ **Make/Model**____ **Cost**____

Did you like them?____ **Why/Why not?**____

If you did not purchase, why not?____

Which ear do you feel is your better hearing ear?____

What do you believe caused your hearing problems?____

Circle One: I work - I'm retired - What is or was your occupation?____

What would be your main hearing problem?____

	Yes	Sometimes	No
1. Do you have difficulty understanding in a crowd?	____	____	____
2. Do you have difficulty hearing in church or meetings?	____	____	____
3. Do you have difficulty hearing and understanding TV?	____	____	____
4. Do you have trouble understanding in a restaurant?	____	____	____
5. Do you have trouble hearing the phone ring?	____	____	____
6. Is it difficult for you to understand on the phone?	____	____	____

F.D.A. & MEDICAL HEARING ASSESSMENT

Have you ever experienced any medical or surgical treatment for hearing loss? _____Yes _____No

Have you experienced any drainage from the ears in the past 90 days? _____Yes _____No

Have you experienced a sudden hearing loss in the past 90 days? _____Yes _____No

Have you experienced acute or chronic dizziness in the past 90 days? _____Yes _____No

Have you experienced any recent pain or discomfort in the ear? _____Yes _____No

Have you experienced any ringing, buzzing or other noises in the ear? _____Yes _____No

Comments or Further Medical Concerns: _____

_____

_____

_____

_____

_____

What is your Medical Insurance? _____

Are you interested in learning more about 0% interest financing for any portion of your hearing aid purchase that may not be covered by your primary insurance?

_____Yes _____No

_____12 Months _____18 Months

FOR OFFICE USE ONLY

HEARING HEALTHCARE PROFESSIONAL AUTHORIZATION

PATIENT CONSENT/ACKNOWLEDGEMENT FORM

By signing below, you consent to the use and disclosure of your protected health information by **George M. Iwanow**, our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting **George Iwanow, H.A.C., Inc.** at **(586) 263-4401** and requesting a revised Notice. We will also post any revised notice in the **George Iwanow H.A.C., Inc.**

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGEMENT.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY.

Name _____ Date_____

PLEASE SPECIFY THE EXACT REASON WHY PATIENT CHOSE NOT TO SIGN THE CONSENT/ACKNOWLEDGEMENT OF NOTICE OF PRIVACY.

_____

_____

_____

ALL FORMS ARE FOR EDUCATIONAL USE ONLY AND DO NOT CONSTITUTE LEGAL ADVICE. ALL FORMS ARE SUBJECT TO CHANGES IN THE FEDERAL LAW AND APPLICABLE STATE LAWS. SEEK LEGAL ADVICE BEFORE USE.

I hereby acknowledge that I have received a copy of this authorization. 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 **George M. Iwanow, H.A.C., Inc.** to use or disclose my health information in the manner described above.

_____ _____

Signature of Patient (or Personal Representative) Effective Date

_____ _____

Print Patient Name Personal Representative's Authority