Davis AUDIOLOGY
Hear your world.

4318 E. North St
Greenville, SC 29615
Phone: (864) 655-8300
Fax: (864) 603-1555

Today's Date: _____

Legal Name: _____ **Preferred Name:**_____

DOB: _____**Gender:** _____**Preferred Pronoun:** _____

Employer:_____ **Name of Primary Care Physician:** _____

What is the primary reason for today's visit? (select all that apply)

☐ Hearing ☐ Tinnitus ☐ Wax Removal ☐ Hearing aid Check

Medical History

Please list medications and dosage (including over-the-counter) you are currently taking or have taken recently:_____

_____

Recent hospitalization or surgeries: _____

_____

Have you ever had significant head trauma? ☐ Yes ☐No Age _____ Type _____

Have you had radiation treatment to head/neck in the last 6 months? ☐ Yes ☐ No

Have you had earaches/ear drainage in the past 90 days? ☐ Yes ☐ No As a child? ☐ Yes ☐ No

Do you have any open sores or bleeding *from your head* today? ☐ Yes ☐ No

Have you ever had medical/surgical treatment *for your ears*? ☐ Yes ☐No If yes, age/type?

_____

Do you have dizziness, balance problems, or falls? ☐ Yes ☐ No Describe: _____

Do you currently take prescription anticoagulant medication? ☐ Yes ☐ No

Do you currently or have you ever had any of the following conditions?

☐ Arthritis	☐ Cancer	☐ Depression/ Anxiety	☐ Hepatitis	☐ HIV	☐ Multiple Sclerosis	☐ Parkinson's	☐ Stroke/TIA
☐ Allergies	☐ Concussion/ Skull Fracture	☐ Diabetes (Type I)	☐ High Blood Pressure	☐ Measles	☐ Mumps	☐ Scarlet Fever	☐ Tuberculosis
☐ Bell's Palsy	☐ Dementia/ Alzheimer's	☐ Diabetes (Type II)	☐ High fevers	☐ Meningitis	☐ Pacemaker	☐ Seizures	☐ Vision Problem

Hearing History

Have you ever been diagnosed with hearing loss? ☐ Yes ☐ No If yes, when and where? _____

_____

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Have you seen a physician for your hearing concerns? ☐ Yes ☐ No If yes, name _____

How long have you noticed hearing/understanding difficulty? ☐ <1 yr ☐ 1-3 yrs ☐ 4-6 yrs ☐ 7+ yrs

☐ Gradual *or* ☐ Sudden Is one ear better? ☐ Right ☐ Left ☐ Equal

Does anyone in your biological family have hearing loss? ☐ Yes ☐ No Who?_____

Have you been exposed to very loud noise (e.g. military, music, gunfire)? ☐ Yes ☐ No

Do you have ringing, buzzing, or roaring (tinnitus) in your ears? ☐ Yes ☐ No
☐ Constant ☐ Sometimes

Please describe the sound:_____

Is it bothersome? ☐ Yes ☐ No

AUTHORIZATION FOR RELEASE OF INFORMATION

I do hereby authorize Davis Audiology, LLC to **furnish and/or to obtain** information concerning

_____with respect to *patient's physicians and*
Patient Name

manufacturers.

1. Primary Care Physician's Name: _____
2. _____

AUTHORIZATION FOR TELEHEALTH SERVICES AND OR USE OR DISCLOSURE OF PATIENT PHOTOGRAPHIC AND OR VIDEO IMAGES

Telehealth allows a hearing care provider to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment.

☐ I hereby consent to participating in hearing care via Telehealth. I understand that confidentiality with Telehealth is under the same laws that protect the confidentiality of my medical information for in-person treatment. I authorize the use and disclosure of my photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA privacy regulations.

☐ I do not wish to participate in Telehealth.

☐ I do not authorize the disclosure of photographic/video images for marketing/testimonial purposes.

Signature_____Date_____

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Patient Financial Responsibility Statement

We ask that you please read and understand your financial responsibilities prior to receiving services.

Financial Information:

1. I understand that I am financially responsible for all charges not paid by insurance. I authorize the release of information to my insurance company for insurance/medical purposes. I hereby authorize payment from my insurance company to Greer Audiology LLC (dba Davis Audiology).
2. I understand that I am solely responsible for obtaining any necessary referrals and/or authorizations prior to my appointment.
3. I understand that if I do not have valid medical insurance, I am financially responsible for all fees at the time services are rendered. Please Note: A copy of your most current insurance card is required to process your visit to insurance if applicable. Failure to provide this may result in Davis Audiology's inability to file your insurance claim for you, if applicable.
4. I understand that I am expected to pay all copays, coinsurance, and deductibles at time of service.
5. I understand I will be charged $30 for any check returned by my bank for any reason.
6. I understand it is my responsibility to inform Davis Audiology if my insurance has changed.

No Show and Late Cancellation Policy:

It is the policy of the practice to monitor and manage appointment no-shows and late cancellations. Davis Audiology's goal is to provide excellent and timely care to each patient. If it is necessary to cancel an appointment, patients are required to call or leave a message at least 24 business hours prior to the scheduled appointment time. Patients will be assessed a fee of $25 for each documented no show or late cancellation. Notifying our practice in a timely manner allows our providers to better utilize appointments for other patients in need of hearing healthcare. In the event a patient has incurred three (3) documented "no-shows" or "late cancellations" within 1 year, the patient may be subject to dismissal from Davis Audiology. Dismissals are determined by the owner after the patient's chart has been reviewed.

The charge for late cancellation/no-show of appointments will be billed directly to you and not to your insurance. We understand that situations such as medical emergencies occasionally arise. These situations will be considered on a case-by-case basis.

By signing below, I acknowledge that I understand and agree to these terms:

_____ _____

Signature Date

_____ _____

Print Date of Birth

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ASSIGNMENT OF INSURANCE BENEFITS

Patients with *insurance* please read and sign below:

Davis Audiology is happy to process your insurance claim for professional services received; however, your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims or accept responsibility for negotiating claims with your insurance company. Charges not paid by your insurance company for professional services rendered such as a diagnostic hearing examination are ultimately the responsibility of the patient. At Davis Audiology patients receive a diagnostic hearing examination performed by a licensed Doctor of Audiology. This is the only way to get a proper and comprehensive assessment of a patient's hearing. This examination is not simply for the purpose of hearing loss related to the purchase of hearing aids. A Doctor of Audiology also has the professional responsibility to look for and rule out other hearing health care conditions/pathologies related to the ear such as; middle ear fluid, ear disease, and either nerve tumors to name a few.

As credentialed Medicare healthcare providers, the Doctors of Audiology at Davis Audiology are required by federal law to charge all patients for their diagnostic hearing examinations. It is unlawful for the Doctors of Audiology at Davis Audiology as Medicare provider to provide a service for free to other patients that is reimbursed by Medicare. Medicare legally requires its providers to treat everyone the same That means a Medicare provider cannot choose to charge some patients for the services they provide and then not charge others for the same service. I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans to Davis Audiology. A photocopy of my insurance card (assignment) and a copy of my driver's license are to be considered as valid as an original. ***I am financially responsible for all charges whether or not paid by the above insurance.*** I hereby authorize Davis Audiology to release all information necessary to secure the payment. ***If insurance pays only a portion of the bill or fails to make payment to Davis Audiology within 90 days, I will be responsible for payment of balance in full at that time. Please Note: A copy of your most current insurance card is required to process your visit to insurance if applicable. Failure to provide this may result in Davis Audiology's inability to file your insurance claim for you, if applicable.***

_____ _____

Signature Date

MEDICARE PATIENTS:

I request payment of authorized Medicare benefits to be made to Davis Audiology for any services rendered. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or related services to pay the claim. If there are other insurance carriers, my signature authorizes releasing of information. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge ***and the patient is responsible for only the deductible, coinsurance and the non-covered services. Coinsurance and the deductible are based upon the charge determined by the Medicare carrier.***

_____ _____

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Falls Risk Awareness and Hearing Health Decisions

Davis Audiology is now pleased to offer Falls Risk Screenings in our Greenville office location. This screening is optional and not covered by health insurance. Davis Audiology feels falls risk screenings provide important information for our patients and therefore will offer this at a nominal rate of **$20**. We highly recommend you opt to have a Falls Risk Screening assessment if you have any of the below **risk factors**:

-Arthritis	-Back, neck or chest pain
-Confusion or memory loss	-Depression or mental fogginess
-Diabetes	-Dizziness or light-headedness
-Fatigue	-Hearing Loss
-High blood pressure	-History of heart attack/cardiovascular disease
-History of falls/loss of balance	-Knee or hip replacement
-Kidney disease	-Sense of motion or spinning

67% of Emergency Room visits by adults age 65-85+ are for falls! An ounce of prevention is worth a pound of cure…. A hearing loss may increase the risk of falls, with negative impact on one's quality of life and longevity. A falls risk screening will provide valuable information to your audiologist and your physician to allow well-informed decisions regarding hearing and balance evaluation and treatment options.

Are you interested in completing the Falls Risk Screening today during your appointment?

☐ Yes	☐ No

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Acknowledgement of Receipt of Privacy Notice

I hereby acknowledge that I reviewed a copy of Davis Audiology's Notice of Privacy Practices.

Signature: _____ Date: _____

If not signed by the patient, please indicate relationship: _____

Disclosure of Medical Information

Your medical information and communication of that information is essential to your care. We prefer to speak directly with each patient but we understand that other individuals or family members may have knowledge of and may be assisting in your care. **Please list the individuals who we are authorized to discuss your care with.** (Note: We cannot discuss your care with others, including your spouse or other family members living with you, unless they are listed below.)

Name of person: _____ Relationship to Patient: _____

Name of person: _____ Relationship to Patient: _____

Name of person: _____ Relationship to Patient: _____

Confidential Communications between Office and Patients

I authorize communications by Davis Audiology concerning scheduled appointments, treatment, practice information and newsletters through the following methods:

Please select all that apply: ☐ Call ☐ Text ☐ Work ☐ Email

Home Phone: (_____) _____-_____ Authorize messages? ☐ Yes ☐No

Cell Phone: (_____) _____-_____ Authorize messages? ☐ Yes ☐No

Work Phone: (_____) _____-_____ Authorize messages? ☐ Yes ☐No

Email: _____

What is your preferred method for *appointment reminders*?

☐ Call ☐ Text ☐ Work ☐ Email

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Name:_____ Date:_____

If you could improve your current hearing status or communication ability, what would you change, if anything?

_____
_____
_____

Do you have specific situations that you are looking to improve (e.g. soft voice, in a restaurant with friends, television, church, meetings)?

_____
_____
_____

Do you have a specific person or people you would like to communicate easier and more effectively with?

_____
_____
_____

Please describe your current lifestyle (i.e., active with friends and family, meetings, volunteer work, restaurants, travel OR more casual/quiet environments, 1 on 1 situations, watching television, phone calls, etc.)

_____
_____
_____

Anything specific you would like to discuss today?

_____
_____
_____