Patient Information

Cincinnati Hearing Center
Sound Advice from Caring Professionals

Patient Name: _____

Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Text OK? □Yes □ No

Work Phone: _____Email: _____

Primary Care Physician: _____

Primary Care Physician Location: _____

Marital Status Spouse's Name: _____

How did you hear about us? _____

In case of emergency, who should we notify? _____

Emergency Contact Phone: _____

Insurance Information:

Primary Health Insurance Carrier_____

Please present your insurance card so we can make a copy for your chart.

I authorize Cincinnati Hearing Center to obtain information from my insurance company concerning my benefits. I also authorize payment of medical benefits to be made directly to Cincinnati Hearing Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance.

Signed: _____ Date: _____

Authorization and Release:

I authorize Cincinnati Hearing Center to obtain any medical record deemed necessary to my treatment. I further authorize Cincinnati Hearing Center to release my hearing information to requesting individuals or agencies.

Signed: _____ Date: _____

6570 Glenway Ave
Cincinnati, OH 45211
Phone 513-598-9444
Fax 513-598-8223

981 State Road 46 East
Batesville, IN 47006
Phone 812-717-2021

www.CncinnatiHearingCenter.com

Health Information:

Name_____ Date of Birth_____ Age_____

Would you like us to send a report to your doctor? _____

What is the reason for today's visit? _____

History of ear disease or surgery? _____

Family history of hearing loss? _____

History of trauma to the head? _____

Do you have dizziness, vertigo, or a loss of balance? _____

Do you have any tinnitus? (ringing, buzzing, hissing) _____

History of exposure to noise? _____

Do you or have you ever worn hearing aids? _____

Patient's Signature_____ **Date**_____

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CONSENT TO USE AND/OR DISCLOSE HEALTH INFORMATION

As part of the new federal **Health Insurance Privacy and Portability Act** we are informing all patients of the appropriate use and disclosure of their protected health information. By signing this form you are granting consent to **Cincinnati Hearing Center** to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our **Notice of Privacy Practices** provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change, if we change our notice, you may obtain a copy of the revised notice by contacting us at 513-598-9444. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

X_____ **Signature Date**

Cincinnati Hearing Center

COMMUNICATION/PRIVACY CONSENT FORM

Due to new HIPPA regulations, we need some information about how to better communicate with you.

Please answer the following questions so we may contact you in the most efficient way possible:

May we leave a message on your answering machine at home?	☐ Yes	☐ No
May we leave a message on/text your cell phone?	☐ Yes	☐ No
May we call you at work and/or leave a message on your work voicemail?	☐ Yes	☐ No
If we call you at home and you are unavailable, may we leave a message with another person?	☐ Yes	☐ No
May we contact you through mail regarding appointments, billing matters and/or new technology?	☐ Yes	☐ No
May we email you?	☐ Yes	☐ No

Preferred method for appointment confirmation: (Please choose one)

□ Phone □ E-mail □ Text

Please list the person//persons to whom you authorize us to release information and their relationship to you.

Name_____Relationship_____

Name_____Relationship_____

_____

Patient's Signature Date

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