PATIENT DEMOGRAPHIC FORM

Patient Information:

Name:

Mr./Mrs./Ms./Miss: _____
First Middle Last

Address: _____ City: _____ State: _____ ZIP: _____

Day Phone: _____ Other Phone: _____ Mobile Phone: _____

Gender: ☐ M ☐ F Date of Birth: _____ Social Security#: _____ (optional)

Marital Status: ☐ Single ☐ Married ☐ Other

Employment Status: ☐ Employed ☐ Retired ☐ Student: (select one) ☐ FT ☐ PT ☐ Other

Companion Name: _____ Phone: _____

Patient's Email: _____ Fax#: _____

Family Doctor: _____ Phone: _____

Referring Physician: _____ Phone: _____

Would you like your results sent to your family doctor? **Y / N** (circle one)

Marketing: How did you hear about our clinic (check all that apply)?

☐ Direct Mail ☐ Internet ☐ Radio
☐ Newspaper ☐ Magazine ☐ Signage
☐ Television ☐ Amplifon Hearing Healthcare ☐ Grassroots
☐ Physican Referral ☐ Managed Care ☐ Yellow Pages
☐ Friend/Patient Referral ☐ Continuous care ☐ Other: _____

Guarantor Information (if patient is a minor):

Parent/Legal Guardian (Guarantor): _____ Social Security#: _____

Address: _____ City: _____ State: _____ ZIP: _____

Day Phone: _____ Other Phone: _____ Mobile Phone: _____

310 Delaware Road • Frederick, MD 21701
www.sonusfrederick.com

Insurance Information; please provide Insurance card(s) with this completed form:

Policy Holder's Name:_____ Policy Holder's Date of Birth: _____

Address:_____ City: _____ State: _____ ZIP:_____

Day Phone: _____ Social Security#: _____

Insurance Company: _____ Insured's ID#: _____

Insured's Policy Group: _____ Policy Holders Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name/Program: _____

Do you have Medicare Coverage? ☐ Yes ☐ No

Policy Holder's Employer Name: _____ Phone: _____

Secondary Insurance Information:

Policy Holder's Name:_____ Policy Holder's Date of Birth:_____

Address:_____ City: _____ State: _____ ZIP:_____

Day Phone: _____ Social Security#: _____

Insurance Company: _____ Insured's ID#: _____

Insured's Policy Group: _____ Policy Holders Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name/Program: _____

Do you have Medicare Coverage? ☐ Yes ☐ No

Policy Holder's Employer Name: _____ Phone: _____

Additional Insurance Information:

Please use additional form to record supplementary insurance.

Workers Compensation Information:

Worker's Comp Company Name:_____ Adjustor's Name:_____

Claim Number:_____ Date of Injury: _____

Employer's Name: _____

Preferences:

Language: _____

Special Needs: _____

Best time of day to contact you: _____

Please complete other side.

Financial Agreement:

We participate in many different insurance plans. We will file your insurance claims for the companies with whom we are contracted. You will be responsible for any co-payments or deductibles at the time services are rendered. For some insurance we accept assignment of benefits but in all cases we require that the guarantor, the person who is financially responsible, is personally liable for all balances not covered by insurance. It is our responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance companies. You will be responsible for co-payment, deductibles, out-of-network amounts or any portion your insurance company indicates is your responsibility. Payment for co-pays are expected at the time of service. If this fee is not covered by insurance it will be your responsibility. We allow your insurance company 45 days to pay your claim. If we do not receive payment in 45 days, you will be given a bill at that time. For our HMO/PPO patients, if we are contracted with your HMO/PPO, you will not receive a bill until we have heard from your insurance company.

Assignment of Insurance Benefits:

I hereby authorize direct payment to Sonus of any insurance or health benefits otherwise payable to or on behalf of the patient for examination, treatment or devices delivered to me by Sonus, at the rate not to exceed Sonus' usual charges. I understand that verification of insurance coverage obtained over the phone or online is estimated and does not guarantee payment and that insurance coverage is a relationship between the patient and his or her insurance company(s). I agree to accept financial responsibility for any charges for goods and services rendered to the patient that are not paid by insurance or health benefit plan pursuant to this assignment of benefits. I have been informed that Medicare does not provide payment for hearing aids, other assistive listening devices or fitting examinations.

Release of Information:

I hereby authorize Sonus to release any medical information about the patient necessary to determine liability for payment and to process any claim for examination, treatment or devices received by the patient. I also authorize Sonus to release the medical records of the patient to the patient's referring physician or family physician indicated on the first page of this form.

Financial Responsibility Agreement by Other than Patient's Legal Representative:

I agree to accept financial responsibility for the good and services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Benefit, and Release of Information provisions above.

I have read and agree to the terms above. Please print entire form. Sign and date below or digitally sign.

_____

Signature of Patient or Legal Representative | Date

_____

Signature of Insurance Policy Holder | Date

_____

Relationship to Patient | Witness (Sonus)

_____
Date

_____
Patient Name

What prompted you to visit our office today?_____

What would you like achieve from your visit?_____

What have you noticed about your hearing ability?_____

How long have you had difficulty hearing?_____

What are others saying about your hearing ability?_____

Have you had a hearing test before?_____ If so, by whom?_____ Date:_____

Yes	No	
☐	☐	Do you have any pain or discomfort in your ear?_____
☐	☐	Do you have any noise/ringing in your ears?_____
☐	☐	Is there a history of hearing loss in your family?_____
☐	☐	Do you have any dizziness or vertigo?_____
☐	☐	Do you have a history of excessive noise exposure?_____
☐	☐	Have you had any ear drainage in the past 90 days?_____
☐	☐	Have you had ear surgery in the past 90 days?_____
☐	☐	Have you had a sudden change in your hearing in the past 90 days?_____

Please list all medications that you are currently taking_____

_____

Do you have any medical conditions we need to be aware of?_____

_____

Who is your primary care physician?_____

How were you referred to our office?_____

Hearing Inventory "HI" for Patient

Patient _____ Date _____ HI Score _____

At Sonus, it is our mission to find the best personal solution for each individual's communication needs. We will only be successful in reaching this goal if we take the time to compile the following information about you.

Please answer the following questions by checking the appropriate response.

	Yes	Sometimes	No
1. Does a hearing problem cause you to feel embarrassed when you meet new people?	☐	☐	☐
2. Does a hearing problem cause you to feel frustrated when talking to members of your family?	☐	☐	☐
3. Do you have difficulty hearing when someone speaks in a whisper?	☐	☐	☐
4. Do you feel burdened by a hearing problem?	☐	☐	☐
5. Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?	☐	☐	☐
6. Does a hearing problem cause you to attend large group situations less often than they would like?	☐	☐	☐
7. Does a hearing problem cause you to have arguments with family members?	☐	☐	☐
8. Does a hearing problem cause you difficulty when listening to TV or radio?	☐	☐	☐
9. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	☐	☐	☐
10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	☐	☐	☐

Adapted from HHIE

Hearing Inventory "HI" for Companion

Name _____ Date _____ HI Score _____

Patient _____ Relationship to Patient _____

At Sonus, it is our mission to find the best personal solution for each individual's communication needs. We will only be successful in reaching this goal if we take the time to compile the following information from those closest to the patient…you!

Please answer the following questions by checking the appropriate response.

	Yes	Sometimes	No
1. Have you observed a situation where a hearing problem caused him/her to feel embarrassed when meeting new people?	☐	☐	☐
2. Do you feel a hearing problem causes him/her to feel frustrated when talking to members of his/her family?	☐	☐	☐
3. Have you noticed that he/she has difficulty hearing when someone speaks in a whisper?	☐	☐	☐
4. Do you believe he/she is burdened by a hearing problem?	☐	☐	☐
5. Are you concerned that a hearing problem causes him/her difficulty when visiting friends, relatives or neighbors?	☐	☐	☐
6. Do you think that a hearing problem causes him/her to attend large group situations less often than they would like?	☐	☐	☐
7. Have you ever felt that a hearing problem causes him/her to have arguments with family members?	☐	☐	☐
8. Have you noticed that a hearing problem causes him/her difficulty when listening to TV or radio?	☐	☐	☐
9. Are you concerned that any difficulty with his/her hearing limits or hampers their personal or social life?	☐	☐	☐
10. Have you observed that a hearing problem causes him/her difficulty when in a restaurant with relatives or friends?	☐	☐	☐

Adapted from HHIE

Patient Email and Text Message Informed Consent

You may give permission to Sonus Hearing Care Professionals to communicate with you by email and text message. This form provides information about the risks of the forms of communication, guidelines for email/text communication, and how we use email/text communication. It also will be used to document your consent for communication with you by email and text message.

1) **How we will use email and text messaging:** We use these methods to communicate only non-sensitive and non-urgent issues. All communications to or from you may be made a part of your medical record. You have the same right of access to such communications as you do to the remainder of your medical record. We will not disclose your emails or text messages to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as to permitted uses of your health information and your rights regarding privacy matters.
2) **Risk of using email and text messages:** The use of email and text message has a number of risks that you should consider. These risks include, but are not limited to the following:
   a) Emails and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
   b) Senders can easily misaddress an email or text and send the information to an undesired recipient.
   c) Backup copies of emails and texts may exist even after the sender and/or recipient has deleted his or her copy.
   d) Employers and online services have a right to inspect emails and texts sent through their company systems.
   e) Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
   f) Emails and texts can be used as evidence in court.
   g) Email and text messaging may not be secure, and therefore it is possible that a third party may breach the confidentiality of such communications.
3) **Conditions of the use of email and text message:** Sonus Hearing Care Professionals cannot guarantee but will use reasonable means to maintain security and confidentiality of email/text information sent and received. You must acknowledge and consent to the following conditions:
   a) **IN A MEDICAL EMERGENCY, DO NOT USE EMAIL, CALL 911**. Do not email for urgent problems. If you have an urgent problem during regular business hours, please call 301-663-0553. Urgent messages or needs should be relayed to us by using regular telephone communication and may include text messages.
   b) Emails should not be time sensitive. While we try to respond to email messages daily, we cannot guarantee that any particular email will be read and responded to within any particular period of time. If you have not heard back from us within three days, call our office to follow up if we have received your email.
   c) You should speak to our office directly to discuss complex and/or sensitive situations rather than send email or text messages regarding such situations.
   d) Email and text messages may be filed electronically into your medical record.
   e) Clinical staff will not forward your identifiable email/texts to outside parties without your written consent, except as authorized by law.
   f) You should use your best judgement when considering the use of email or text messages for communication of sensitive medical information. Clinical staff are not responsible for the content of messages.
   g) Sonus Hearing Care Professionals is not liable for breaches of confidentiality caused by you or any third party.
   h) It is your responsibility to follow up with Sonus Hearing Care Professionals if warranted.
4) **Withdrawal of consent:** I understand that I may revoke this consent at any time by so advising Sonus Hearing Care Professionals in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am entitled.
5) **Patient Acknowledgement and Agreement:** I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of email and text messaging as a form of communication between Sonus Hearing Care Professionals and me, and consent to the conditions and instruction outlined, as well as any other instructions Sonus Hearing Care Professionals may impose to communicate with me by email or text message.

Email: _____ Cell: _____

Patient Name: _____

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

By my signature below I acknowledge that I have received the HIPPA Notice of Privacy Practices (the "Notice") from Sonus Frederick and that I have been provided an opportunity to review it.

I understand that I have certain rights to privacy regarding my protected health information.

I understand that Sonus Frederick can and will use my health information for purposes of my treatment, payment for treatment and health care operations.

I have read and understand that Sonus Frederick may use and share my protected health information for other purposes, as described in the Notice.

I understand that I have rights regarding my protected health information as listed in the Notice.

I understand that Sonus Frederick has the right to change the Notice from time to time and I can obtain a current copy of the Notice from Sonus Frederick at any time.

_____ _____

Patient/Patient's Representative Signature Date

Patient Name (First, MI, Last): _____

Patient Date of Birth (MM/DD/YY)_____

If you are signing as the Patient's representative:

Print your name (First, MI, Last):_____

Describe your relationship_____

I authorize you to give information to the following people on my behalf:

Name_____ relationship_____

Name_____ relationship_____

Internal use only:

Good Faith Effort to Obtain Acknowledgement Form

*Patient Name:*_____ *Date*_____

I attempted to obtain the patient's (or their representative's) signature on this Notice of Privacy Practices Acknowledgement Form, but was unable to do so as documented below:

*Reason*_____

*Name:*_____*Signature*_____

To request this list of disclosures, you must complete and return a Request for Accounting of Disclosures Form (a copy of which is available upon request). Your request must state a time period for which you would like the accounting. The accounting period may not go back further than six years from the date of the request, and it may not include dates before April 14, 2003. You may receive one free accounting in any 12-month period. We will charge you for additional requests.

- **Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you. For example, you could ask that we not use or disclose information about treatment that you received to other health care providers or to your insurance company. *We are not required to agree to your request.* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must complete and return an Authorization for the Use and Disclosure of Protected Health Information Form (a copy of which is available upon request).

- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you only at work or only by mail. To request confidential communications, you must complete and return a Confidential Communication Request Form (a copy of which is available upon request). We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted, and we may require you to provide information about how payment will be handled.

- **Right to a Paper Copy of This Notice:** You have the right to receive a paper copy of this notice. You may ask us to give you a copy of this notice any time. This notice is on our website, ***www.sonus.com***.

Changes to This Notice

The effective date of this notice is April 14, 2003. We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you, as well as any information we receive in the future. If the terms of this notice are changed, Sonus will provide you with a revised notice upon request, and we will post the revised notice on our website and in designated locations at Sonus.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with Sonus, please complete and return a Complaint Form (a copy of which is available upon request) or contact our Compliance Officer at 1-888-333-9152. All complaints must be submitted in writing. *You will not be penalized for filing a complaint.*

Other Uses of Medical Information

Except as described above, Sonus will not use or disclose your protected health information without a specific written authorization from you. If you provide us with this written authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization, except to the extent we have already relied on your authorization. We are unable to take back any disclosures we have already made with your permission, and we are required to retain our records of the care that we provided to you.

1159SNCB/C

sonus hearing care professionals

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

During your treatment at Sonus, Inc. ("Sonus"). Sonus and members of its staff may gather information about your medical history and your current health. This notice explains how that information may be used and shared with others. It also explains your privacy rights regarding this kind of information. The terms of this notice apply to health information created or received by Sonus. We are required by law to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect.

Your medical information may be used and disclosed for the following purposes:

- **Treatment:** We may use your information to provide, coordinate, and manage your care and treatment. For example, a Sonus staff member may share your medical information with another health care provider for a consultation or a referral.

- **Payment:** We may use and disclose medical information about you so that the treatment and services you receive may be billed to, and payment may be collected from, you, an insurance company, or another third party. For example, we may need to give your health plan information about treatment you received at Sonus so your health plan will pay us or reimburse you for the treatment.

- **Health Care Operations:** We may use and disclose medical information about you for Sonus' health care operations. Health care operations are the uses and disclosures of information that are necessary to run Sonus and to make sure that all of our customers receive quality care. For example, we may use medical information to evaluate the performance of our staff in caring for you.

- **Appointment Reminders and Other Health Information:** We may use your medical information to send you reminders about future appointments. We may also contact you with information about new or alternative treatments or other health care services.

- **To People Assisting in Your Care.** If you are unable to make health care decisions, Sonus will disclose relevant medical information to family members or other responsible persons, such as those with Power of Attorney or those with your express written approval if it is in you best interest, including an emergency situation.

- **Research:** Federal law permits Sonus to use and disclose medical information about you for research purposes, either with your specific, written authorization or, where allowed by state law, when the study has been reviewed for privacy protection by an Institutional Review Board or Privacy Board before the research begins. In some cases, researchers may be permitted to use information in a limited way to determine whether the study or the potential participants are appropriate. If required to do so by applicable law, we will obtain your consent before we disclose your health information to an outside researcher.

- **To Business Associates:** Some services are provided by or to Sonus through contracts with business associates. Examples include Sonus attorneys, consultants, collection agencies, and accreditation organizations. We may disclose information about you to our business associate so that they can perform the job we have contracted with them to do.

In all of the situations described above, *where required to do so by law,* Sonus will obtain your written permission prior to disclosing your health information.

Your medical information may be released in the following special situations:

We may also use or disclose your information, without your permission, for the following purposes to the extent permitted or required by law:

– Under emergency conditions, to government or other groups assisting in emergencies or disasters;
– When required by law;
– For public health activities, including, without limitation, to report disease and vital statistics, child abuse, and adult abuse or neglect or domestic violence;
– For health oversight activities, such as activities of state licensing and peer review authorities, and fraud prevention enforcement agencies;
– For judicial and administrative proceedings;
– To avert a serious threat to health or safety;
– To law enforcement officials with regard to crime victims, crimes on our premises, crime reporting in emergencies, and identifying and locating suspects or other persons.
– For certain specialized government functions, such as military discharge;
– To the military, to federal officials for lawful intelligence, counterintelligence, national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody;
– As authorized by the state's worker's compensation laws.

In all of the situations described above, *where required to do so by law,* Sonus will obtain your specific written permission prior to disclosing HIV-related information, mental health records, drug or alcohol abuse records, or any other type of record given explicit additional protections under applicable state law.

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy:** You have the right to inspect and receive a copy of your medical information that is used to make decisions about your care. Usually, this includes medical and billing records maintained by Sonus.

If you wish to inspect and copy medical information, you must complete and return a Request for Access to Health Information (a copy of which is available upon request). If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request, to the extent permitted by state and federal law. We may deny your request to inspect and copy your information in certain very limited circumstances. For example, we may deny access if your physician believes it will be harmful to your health, or could cause a threat to others. If you are denied access to medical information, you may request that the denial be reviewed. Another health care provider chosen by Sonus will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Request Amendment:** If you believe that medical information we have about you is incorrect or incomplete, you have the right to ask us to change the information. You have the right to request an amendment for as long as the information is kept by or for Sonus. To request a change to your information, you must complete and return a Request for Amendment Form (a copy of which is available upon request). In addition, you must provide a reason that supports your request. Sonus may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

– Was not created by Sonus, unless the person or entity that created the information is no longer available to make the amendment;
– Is not part of the medical information kept by or for Sonus;
– Is not part of the information which you would be permitted to inspect and copy; or
– Is accurate and complete.

- **Right to an Accounting of Disclosures:** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. This list will not include disclosures for treatment, payment, and health care operations; disclosures that you have authorized or that have been made to you; disclosures for facility directories; disclosures for national security or intelligence purposes; disclosures to correctional institutions or law enforcement with custody of you; disclosures that took place before April 14, 2003; and certain other disclosures.