RHODES
CENTERS FOR BETTER HEARING

Name _____ DOB: _____

Address _____

City _____ State _____ ZIP _____ Email _____

Best Number (_____) _____-_____ Secondary Phone (_____) _____-_____

How would you prefer to be contacted for follow up care? ☐ Text ☐ Email ☐ Phone ☐ Letter

☐ Medicare ☐ Medicaid ☐ BCBS ☐ United ☐ CIGNA ☐ Other_____

Did you retire from Honeywell, USEC, Caterpillar, State of Illinois, or Cook Coal? ☐ Yes ☐ No

Employer/retired from _____ Previous/current occupation _____

☐ Married ☐ Single ☐ Widowed ☐ Divorced

Who is your family doctor? _____ (A copy of your report will be faxed to your physician)

Have you seen our ads: TV, what channel? _____ Website, how did you find our site? _____

Newspaper, what paper? _____ Other, please specify? _____

What motivated you to choose us as your preferred provider? _____

Did someone refer you to us? Who? _____

Health Insurance Portability & Accountability Act of 1996

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to: (A) Provide and coordinate my treatment among health care providers who may be involved in that treatment. (B) Obtain payment from third-party payers for my health care services. (C) Conduct normal health care operations such as quality assessment and improvement activities. (D) Communicate information related to hearing care products or services.

I have been informed of Rhodes Centers for Better Hearings *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that Rhodes Centers for Better Hearing has the right to change the *Notice of Privacy Practices* and that I may contact this office to obtain a current copy of the *Notice of Privacy Practices*. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide.

Sign _____ Date _____

Disclose my protected health information to the parties in the *Notice of Privacy Practices* and the following: (ex. spouse, child)

Name/s (spouse, child, etc.) _____

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What would you like us to help you with today? _____

_____

Have you been exposed to loud noises? Music Machinery Gunfire Engines Other

Do others complain that you watch television with the volume too high? YES NO

Do you have trouble understanding others on the phone? YES NO

Do you have difficulty understanding what is being said in noisy places? YES NO

Do you ever feel that you "can hear, but can't understand?" YES NO

Do you have ear pain, ear drainage, dizziness, or a history of ear surgery? YES NO

Is there a history of hearing loss in your family? YES NO

Do you have ringing or noise (tinnitus) in your ears? YES NO

If applicable, is your tinnitus bothersome? YES NO

Would you be willing to wear hearing instruments if they would help you? YES NO

Have you ever made an investment in hearing instruments? YES NO

How long have you worn hearing instruments? _____

What would improve your current hearing instruments? _____

Have you previously seen an Ear, Nose, and Throat physician? Who? _____When? _____

If hearing instruments were recommended, which is **most** important to you? (Circle One) Cost Cosmetics Clarity

Which most accurately describes your lifestyle:

☐ Active Lifestyle (frequent background noise)

☐ Casual Lifestyle (occasional background noise)

☐ Quiet Lifestyle (limited background noise)

☐ Very Quiet Lifestyle (Rare background noise)

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Companion Questionnaire

Name: _____

Relation to Patient: _____

Is it difficult for your companion to understand others on the telephone? YES NO

Is it difficult for your companion to hear the television or radio? YES NO

Does your companion have difficulty understanding what is being said in noisy places? YES NO

Does your companion's hearing problem hamper your personal or social life? YES NO

Does your companion hear people speak but fail to understand what they are saying? YES NO

How long have you noticed your companion's hearing problem? _____

If hearing instruments were recommended to your companion, which is most important to you?

Cost Cosmetics Clarity

Which most accurately describes your companion's lifestyle:

☐ Active Lifestyle (frequent background noise)

☐ Casual Lifestyle (occasional background noise)

☐ Quiet Lifestyle (limited background noise)

☐ Very Quiet Lifestyle (Rare background noise)

Is there anything about your companion that you would like us to know?

_____

_____

_____