DECIBEL
HEARING SERVICES
www.decibelhearing.com

Intake Form

Patient Name ________________________________ Sex ☐ M ☐ F
First MI Last

Address ________________________________
Street City State Zip

Home Phone ____________________ Cell Phone ____________________

Email ____________________ SSN ____________ Date of Birth ________

Occupation ____________________ Marital Status ☐ Married ☐ Single

Emergency Contact ____________________ Phone ____________________

Relationship to Patient ________________________________

Primary Care Physician ____________________ Phone ____________________

Name of Insured (if other than patient) ________________________________
First Last MI

Relationship to Patient ____________________ Subscribers Date of Birth ____________________

How did you find out about us?

- ☐ Yellow Pages
- ☐ Internet
- ☐ Referred by Patient ____________________
- ☐ Advertisement
- ☐ Insurance
- ☐ Referred by Physician ____________________
- ☐ Consumer Seminar
- ☐ Employer
- ☐ Other ____________________

PLEASE READ CAREFULLY, CHECK THE BOXES AND SIGN BELOW

- ☐ I agree I am ultimately responsible for the balance of my account for services rendered.
- ☐ I acknowledge I have received the Health Insurance Portability and Accountability Act policy for this office.
- ☐ I give permission to this practice to release information, verbal and written, contained in my medical record and other related information to my insurance company, healthcare providers, employers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.
- ☐ The FDA has determined it is in my best interest to have a medical evaluation by a licensed physician (preferably a physician who specializes in diseases of the ear) before purchasing hearing devices. I have been advised by the practice and/or its agents about this determination and hereby waive this requirement.

I have read all the information on this form, agree to the checked boxes above, certify this information is true and correct to the best of my knowledge and hereby give my permission to the practice to treat my concerns.

I have read, understand and agree to the above information.

________________________________ ____________
Patient Signature Date

________________________________ ____________
Legal Guardian if Patient is a Minor Date

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Pediatric Case History

Client Name ____________________ D.O.B. ____________ Date ____________

Physician ____________________ Phone ____________________

Accompanying Person(s) ____________________ Relationship ____________________

____________________ ____________________

____________________ ____________________

1. Reason for visit ____________________
2. Have you noticed a hearing problem? ____________________
3. Previous hearing testing?
   When? ____________________
   Where? ____________________
   Results? ____________________
4. Is there a history of high fevers? ____________________
5. Is there a history of ear infections?
   How frequently? ____________________
   Date of last infection? ____________________
   How was it treated? ____________________
6. Is there a history of seizures? ____________________
7. Is there a history of cleft lip or palate? ____________________
8. Is there a family history of hearing impairment? ____________________
   Relationship? ____________________
   Age of onset? ____________________
9. Is there a history of head trauma? ____________________
   When? ____________________
   Medical evaluation and findings? ____________________
   Was hearing affected? ____________________
10. Is there a history of hospitalization for:
    - ☐ Meningitis
    - ☐ Encephalitis
    - ☐ Measles
    - ☐ Influenza
    - ☐ Rubella
    - ☐ Cytomegalovirus (CMV)
    - ☐ Septicemia
    - ☐ Diabetes
    - ☐ Heart Disease
    - ☐ Other ____________________
11. Is there a history of exposure to IV antibiotics, chemotherapy, chemicals, or radiation? ____________________

Other comments

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2655 First St., Suite 170, Simi Valley, CA 93065 • 805.584.3327

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Ellen Baker, AuD
Kelley Bannon, AuD
Caitlin Davis, AuD

Patient Confidentiality Agreement

In order to comply with HIPAA standards and give our patients the best care possible, we require that a patient give us the authorization to discuss their medical records with any referring and/or referred medical providers.

Please list medical providers below:

	Name	**Phone #**
1.		
2.		
3.		

In the event you are unavailable to be contacted by our office, please indicate any family member or friend that we can release any or all information relating to your care.

	Name	**Phone #**
1.		
2.		
3.		

By signing this agreement you allow Decibel Hearing Services staff access to your medical records, the release of your records to the above listed physicians and the release of medical information to the parties listed above.

______________________________ ____________________

Patient/Guardian Signature Date

____

Print Patient Name

Notice of HIPAA Privacy Practices (Short Version)

Decibel Hearing Services

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

Our legal Duty
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described In the Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

Uses and Disclosures of Health Information
We use and disclose health information about you for treatment, payment, and healthcare operations.

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization when it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice or allowed under the Law.

To Your Family and Friends: We may disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree, that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health, incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the persons' involvement in your healthcare. We will allow a person to pick up filled prescriptions, medical supplies, X-rays or other similar forms of health information only upon your **written authorization.** In case of your incapacity we will use our professional judgment and our experience with common practice to make reasonable inferences of your best Interest in providing prescriptions, medical supplies, X-rays and/or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose you health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose a portion of your health information to provide you with results of test, procedures, and/or appointment reminders (such as voice mail messages, postcards, or letters).

Patient Rights

Access: You have the right to look at or obtain copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you. 10 for each page, $15.00 per hour for staff time to locate and copy your health information and postage if you want the copies mailed to you. If you prefer, we will provide a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations & certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations, unless we cannot practically do so. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health & Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health & Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health & Human Services.