HEARING CENTER
Eye Consultants of Atlanta

3225 Cumberland Blvd. SE Suite 175
Atlanta, GA 30339
404-591-2950
Mon-Thurs 8:00 am - 4:30 pm
Fri 8:00 am - 4:00 pm

Date

PERSONAL INFORMATION

Name _____ _____ _____ _____
Title First MI Last

Address _____

City _____ State ____ Zip _____ ☐ DO NOT send any print mailings

Date of Birth _____ Gender ◯ Female ◯ Male Soc. Sec.# _____
MM/DD/YYYY

Email _____ ___DO NOT email special offers ☐ DO NOT email for any reason

Home phone _____ Mobile phone _____ ☐ DO NOT text Work phone _____

Marital status _____ Employment status _____

ALTERNATE CONTACT INFORMATION

Name _____ _____ _____ _____ ☐ Is primary contact
Title First MI Last

Address _____

City _____ State ____ Zip _____ ☐ Use alternate contact for billing

Relationship to patient _____

Email _____ ☐ DO NOT email for any reason

Home phone _____ Mobile phone _____ ☐ DO NOT text Work phone _____

PRIMARY INSURANCE INFORMATION

Insurer name _____

Insurance ID no. _____

Insurance group no. _____

Primary subscriber _____ Gender ◯ Female ◯ Male
Last name, First name

Date of birth _____ Relationship to patient Self

Address of subscriber
if different than patient _____
Street address

_____ _____ _____
City State Zip

Insurance company
phone (provider services) _____

SECONDARY INSURANCE INFORMATION

Insurer name _____

Insurance ID no. _____

Insurance group no. _____

Primary subscriber
Last name, First name _____ Gender ◯ Female ◯ Male

Date of birth _____ Relationship to patient Self

Address of subscriber
if different than patient _____
Street address

_____ _____ _____
City State Zip

Insurance company
phone (provider
services) _____

REFERRAL INFORMATION

Who referred you or how did you find out about us? _____

Primary Care Physician _____ Clinic Name _____

☐ By checking this box, I consent to having my medical test results and findings shared with the referring physician

PATIENT OR GUARDIAN SIGNATURE

_____
Please sign here

HEARING CENTER
Eye Consultants of Atlanta

Consent to Treat

I consent to medical care and procedures while I am a patient at Eye Consultants Hearing Aid Center, LLC. This includes non-invasive testing or procedures, such as routine hearing exams, cerumen (wax) removal, insertion of real-ear probes, and earmold impressions.

The routine procedures will be performed by a licensed Audiologist. While these procedures are routinely performed without incident, there may be a material risk associated with each. It is not possible to list every risk for every procedure, but in rare circumstances, the procedure may cause injury to the ear canal that can result in some bleeding, perforation of the eardrum, tinnitus, or dizziness. Certain risk factors (e.g. blood thinners) may make it more likely for you to incur complications such as bleeding or irritation during a routine procedure such as cerumen (wax) removal.

If I have any questions or concerns regarding these procedures, I will ask my Audiologist for more information. If I do not consent to a procedure, I will tell my Audiologist when they recommend a procedure.

X _____ **X** _____

Patient Signature **Date of Signature**
(OR Parent/Guardian/Authorized Person to Sign for Patient)

X _____

Relationship to Patient

Financial and Insurance Policy

We are committed to meeting your hearing healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines:

1. You are ultimately responsible for payment of charges for services you receive from our office. Hearing aids, hearing aid related services and cerumen (wax) removal usually are not covered services on medical insurance plans. **Therefore, payment is expected at the time of service.**

2. It is your responsibility to provide us with your current address, telephone number, email address and insurance information **at each visit**.

3. It is your responsibility to contact your insurance carrier to confirm that the doctor you are seeing is a participant in your plan. If you see a doctor that is not currently in network with your insurance plan, you will be responsible for payment in full at the time of service.

4. **Medicare Recipients:** We are a participating Medicare practice and will file your Medicare claim. Medicare does not always cover routine hearing examinations, even with a referral from your physician, and may incur charges. Medicare also does not cover cerumen removal when performed by an audiologist, hearing aids or hearing aid services. Therefore, payment is expected at the time of service for services that Medicare may not pay.

5. We do not obtain prior approvals or referrals. This is your responsibility to provide to our office if necessary for coverage of services.

6. We will mail you a monthly statement for any outstanding balances. If your claim has not been paid by your insurance carrier within 30 days of the date of service, please contact your carrier and assist us in getting your claim paid. We will attempt to refile your claim twice. If the second attempt is unsuccessful, the balance will be assigned to patient responsibility for prompt payment.

7. If you are experiencing personal circumstances that will make payment of our charges difficult for you, please contact our office at 404-591-2950.

8. For your convenience, we accept cash, personal checks, Visa, Mastercard, and Discover.

9. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.

I acknowledge that I understand and accept this financial and office policy.

X _____ **X** _____

Patient Signature **Date of Signature**

(OR Parent/Guardian/Authorized Person to Sign for Patient)

X _____

Relationship to Patient

HEARING CENTER
Eye Consultants of Atlanta

Release of information

This authorization remains in effect unless removed by me in writing:

I hereby authorize Eye Consultants Hearing Aid Center, LLC; hereinafter referred to as "ECAHC," to provide information concerning any treatment rendered to me, or to any member of my family, to: a) my insurance carrier(s); b) any physician who referred me to ECAHC; and c) any medical practitioner ECAHC audiologists may refer me (them) to for further medical or therapy treatment.

I authorize the release of any medical information, including confidential information related to psychiatric care, drug, and alcohol abuse, and HIV/AIDS treatments, necessary to process insurance claims or required for utilization review or quality assurance activities.

I further authorize ECAHC to utilize any modern form of transferring this documentation – including, but not limited to, the US mail, Federal Express, telefacimilie (faxes), or other similar methods – to its requested destination.

X _____
Patient Signature
(OR Parent/Guardian/Authorized Person to Sign for Patient)

X _____
Date of Signature

X _____
Relationship to Patient

HEARING CENTER
Eye Consultants of Atlanta

Office Policy

1. If you are more than 15 minutes late to your scheduled appointment, we will have to ask you to reschedule. Due to the individual care that our Audiologist provide each patient, their schedule does not allow flexibility without negatively affecting other patients.

2. If you are unable to keep your scheduled appointment and do not call us to cancel or reschedule the appointment, there will be a $50 charge. We must receive notification of this change no later than 24 hours before the scheduled appointment.

3. Patients under 18 years of age must be accompanied by a parent or guardian. This is required by law and serves to protect you and your child.

X _____ **X** _____

Patient Signature **Date of Signature**

(OR Parent/Guardian/Authorized Person to Sign for Patient)

X _____

Relationship to Patient

HEARING CENTER
Eye Consultants of Atlanta

Notice of Privacy Practices Acknowledgement
Patient Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting **Jack Rogers, COO at (404) 351-2220 extension 1504.**

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

X _____
Patient Signature
(OR Parent/Guardian/Authorized Person to Sign for Patient)

X _____
Date of Signature

X _____
Relationship to Patient

HEARING CENTER
Eye Consultants of Atlanta

OPTIONAL

Patient name: _____

Patient date of birth: _____

Preferred language: _____

Race ☐ **Declined to specify**

☐ White
☐ Black or African American
☐ American Indian or Alaskan Native
☐ Other
☐ Asian
☐ Caucasian
☐ Native Hawaiian or Other Pacific Islander

Ethnicity ☐ **Declined to specify**

☐ Unknown / Not Reported
☐ Not Hispanic or Latino
☐ Hispanic or Latino

**CMS (Medicare) and the Office of the National Coordinator for Health Information Technology (ONC) have established standards and other criteria for structured data that EHRs must use in order to be compliant with government regulations.

HEARING CENTER
Eye Consultants of Atlanta

Eye Consultants of Atlanta Hearing Aid Center, LLC COVID Disclaimer

I understand that Eye Consultants of Atlanta Hearing Aid Center, LLC, its doctors, nurses and staff are taking precautions to limit any potential exposure I may have to the COVD-19 virus. I also understand that there is a no definitive way to eliminate potential exposure by one hundred percent. By checking this box below, I agree that I will not hold Eye Consultants of Atlanta Hearing Aid Center or any of its doctors, nurses, staff or facilities personally responsible should I, someone I come in contact with, become positively or presumptively positively diagnosed with the COVID-19 virus. There are certain inherent risks associated with hearing healthcare during an epidemic and I assume full responsibility for personal illness that may result and further release and discharge Eye Consultants of Atlanta Hearing Aid Center and its doctors and staff for injury, loss or damage arising out of my visit. I understand that COVID-19 infection can lead to illness, disability, or even death and knowingly take the risk of exposure as I deem my hearing exam to be essential to the maintenance of my hearing.

☐ **I understand and agree to the COVID disclaimer.**

X _____ **X** _____

Patient Signature **Date of Signature**

(OR Parent/Guardian/Authorized Person to Sign for Patient)

X _____

Relationship to Patient

General Health History

Name: _____ Date of birth: _____ Date: _____

Have you had or currently have:

- ☐ Chronic ear infections
- ☐ Chronic sinus infections
- ☐ Head Trauma
- ☐ Skull fracture
- ☐ Auto-immune disease
  Diagnosis:_____
- ☐ Diabetes
- ☐ Parkinson's
- ☐ Kidney disease
- ☐ Arthritis
- ☐ Hypertension
- ☐ Stroke or heart attack
- ☐ Pacemaker
- ☐ Vascular disease
- ☐ Chronic lung disease
- ☐ Cancer
  Type:_____
- ☐ Chemotherapy
- ☐ Radiation
- ☐ Memory concerns
  If yes, ☐diagnosed or ☐suspected
- ☐ Alzheimer's disease
- ☐ Dementia
- ☐ Balance concerns
- ☐ Dizziness/Vertigo/Loss of balance
- ☐ Noise exposure
- ☐ Bell's Palsy
- ☐ Allergy problems
- ☐ Meningitis
- ☐ Scarlet fever
- ☐ Measles
- ☐ Mumps
- ☐ Multiple sclerosis
- ☐ HIV
- ☐ Hepatitis
- ☐ Visual impairment
- ☐ Peripheral neuropathy
- ☐ Chronic depression
- ☐ Chronic anxiety
- ☐ Other:

Current Medications (Including any erectile dysfunction or prostate medications as they may cause hearing loss):
If you have a written/printed list, please feel free to provide a copy

Do you take any blood thinners other than aspirin? ☐Yes ☐No

Personal Wellbeing: To what extent do you agree or disagree with these?

I am satisfied with my life:

☐Strongly agree ☐Agree ☐Neither agree or disagree ☐Disagree

What I do in my life is worthwhile:

☐Strongly agree ☐Agree ☐Neither agree or disagree ☐Disagree

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(0= not at all; 1= Several Days; 2= More than half the days; 3= Nearly every day)

Little interest or pleasure of doing things?

☐0 ☐1 ☐2 ☐3

Feeling down, depressed or hopeless?

☐0 ☐1 ☐2 ☐3

Hearing Health History

Name: _____ Date of birth:_____ Date: _____

What would you like to accomplish at today's appointment?

Are you experiencing problems with your hearing? ☐ Yes ☐ No

Which Ear? ☐ Both ears ☐ Right ear ☐ Left ear ☐ None

How long have you noticed problems with your hearing?

☐ Recently ☐ 1-3 years ☐ 4-6 years ☐ 7- 10 years ☐ More than 10 years

Do you have a family history of hearing loss? ☐ Yes ☐ No

Have you had your hearing tested before? ☐ Yes ☐ No

By whom and when?_____

Results? _____

Have you had any of the following? (Check all that apply)

☐ Medically diagnosed ear pathology ☐ Ear pain

☐ Pressure or fullness in ears ☐ Ear drainage

☐ Sudden hearing loss ☐ Ear surgery

☐ Excessive ear wax ☐ Sensitivity to loud sports

Do you currently wear hearing aids? ☐ Yes ☐ No

If so, describe your satisfaction:

Have you ever been exposed to excessive noise levels without hearing protection on any of the following situation?

☐ Workplace ☐ Music ☐ Military ☐ Motorcycle ☐ Firearms ☐ Power Tools ☐ Lawn Mower

☐ Other: _____

Have you ever fallen? ☐ Yes ☐ No

If yes, Number of falls in the past 12 months:

Did you have an injury from the fall? ☐ Yes ☐ No

Do you hear noises in your ears or head? (Tinnitus) ☐ Yes ☐ No

Which Ear? ☐ Both ears ☐ Right ear ☐ Left ear ☐ None

If yes, how often do you hear the noise?

☐ Constantly ☐ Frequently ☐ Occasionally ☐ Very seldom