TEXAS HEARING CLINIC

1340 Wonder World Drive, Suite 4301
San Marcos TX 78666
Phone: 1 (855) 547 - 8369
Fax: 1 (512) 353 - 8862
Jasmine N. Burrington, Au.D., CCC-A

Patient Information:

Name:			Date of Birth:	Sex: M F
Address:		City:	State:	Zip:
Phone:	Cell:	Email:		
Marital Status:		Occupation:		
Referred By:			Primary Physician:	

Responsible Party Information: (Person responsible for payments not covered by insurance if not self-insured)

Name of Responsible Party:			
Relationship to Patient:	Sex: M F	Date of Birth:	
Address:	City:	State:	Zip:
Phone:	Email:		

Insurance Information: (insurance address is on back of insurance card)

Insurance Company/Carrier:			Phone #:	
Address:		City:	State:	Zip:
Name of Policy Holder:				
Member #:	Group #:	Policy Holder Date of Birth:		
Employer Insurance Plan: Yes No	Employer:			

Insurance Company/Carrier:			Phone #:	
Address:		City:	State:	Zip:
Name of Policy Holder:				
Member #:	Group #:	Policy Holder Date of Birth:		
Employer Insurance Plan: Yes No	Employer:			

CONSENT TO TREAT – ASSIGNMENT OF BENEFITS – FINANCIAL AGREEMENT – HIPAA

While I am here, I permit the employees, the doctor and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand the medical provider will explain to me the nature of my condition and his/her recommended treatment and any associated risk involved. I also understand that he/she will explain to me other ways this condition could be treated. I further understand that this care may include tests, examinations, medical and/or surgical treatment. No guarantees have been made to me about the outcome of this care.

I hereby authorize Texas Hearing Clinic to release all information necessary to secure payment. I assign all benefits for unpaid services to with I am entitled to Texas Hearing Clinic. 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 request that payment of authorized Medicare and Medigap benefits be made on my behalf to Texas Hearing Clinic. I authorize any holder of medical information about me to release to Medicare (HCFA) and its agents and/or Medigap any information needed to determine these benefits or the benefits payable for related services.

I have received and read the Financial Policy, and understand I am financial responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees.

By signing below, I acknowledge receipt of Texas Hearing Clinic Notice of Patient Privacy Practices "Acknowledgement."

Signature: ______________________________ Date: ____________

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Authorization for Release of Medical Information

I, *(print name here)*________________________________ hereby authorize facility Texas Hearing Clinics, LLC to release the complete history records in your possession.

Send Records To:

____
____
____
____

Send Records From:

____
____
____
____

I understand that this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. If revocation is not received, authorization will be considered valid for a period of time not to exceed 90 days.

The facility and its employees are released from legal responsibility or liability for the release of the requested information to the extent indicated and authorized herein.

I understand that the information released could contain reference to or results of HIV Antibody (AIDS) testing, and/or alcohol or substance abuse.

Date:____________________________ Signed:____

Witness:__________________________ Date of birth:____

Appropriate Dates of Information Needed:______________________________

Information Needed:____
____

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Adult Hearing Assessment: Health History

Patient Name: ______________________ DOB: ____________ Date: ____________ Gender: ○ M ○ F

Hearing:

Have you had a hearing evaluation? ○ Yes ○ No

Do you feel that you have a hearing loss? ○ Yes ○ No

If yes, when did it begin? ______________________

Do you know what caused your hearing loss? ______________________

Describe your area of primary difficulty: ______________________

Do you have a better ear? ○ Left ○ Right ○ Equal

Do you wear hearing devices? ○ Yes ○ No

Do you avoid social occasions due to difficulty hearing? ○ Yes ○ No

Do you find yourself having to ask people to repeat? ○ Yes ○ No

Do you sometimes hear words but not understand? ○ Yes ○ No

Do you have difficulty understanding people in noisy places? ○ Yes ○ No

Do others complain of the TV being too loud? ○ Yes ○ No

Does anyone in your family have hearing loss? ○ Yes ○ No

Have you worked around hazardous noise? ○ Yes ○ No

If yes, please describe: ______________________

Have you had middle ear infections? ○ Yes ○ No

Any ear surgeries performed? ______________________

Tinnitus:

Do you hear ringing in your ears? ○ Yes ○ No

If yes, describe the sound: ______________________

Is the sound distressing to you? ○ Yes ○ No

Balance:

Do you have any dizziness, vertigo, or unsteadiness? ○ Yes ○ No

If yes, please describe: ______________________

Systems History: *Please check all that apply:*

Nose/Throat/Mouth:

○ Chronic congestion or sinus infections
○ Thyroid problems

Psychiatric:

○ Anxiety
○ Unusual amount of stress
○ Depression
○ Sleep problems

Neurological:

○ Migraines
○ Fainting spells
○ Weakness
○ Tremors
○ Seizures
○ Memory loss
○ Poor attention
○ Head injury

Cancer: ○ Yes ○ No

Previous Diagnosis:

Please check all diagnoses previously received:

○ Mumps
○ Measles
○ Rubella