4491 Long Prairie Road Ste 400, Flower Mound, TX 75028
Phone 817-997-4084
Fax 817-333-1190
www.flowermoundfamilyhearing.com

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Address: _____

City, State and Zip: _____

Home Phone: _____ Date of Birth: _____

Cell Phone: _____ SSN: _____

Email Address: _____

Emergency Contact: _____ Phone: _____

Employment Status: Full Time ❑ Part Time ❑ Student ❑ Retired ❑ Sex: Male ❑ Female ❑

Marital Status: Single ❑ Married ❑ Widowed ❑ Divorced ❑

Referring Physician: _____ Primary Physician: _____

Insurance Information

Primary Insurance:

Plan Name: _____ Policy/ID#: _____ Group #:_____

Subscriber's Name: _____ Patient Relationship to Subscriber: _____

Subscriber's DOB: _____ Subscriber's Employer: _____

Secondary Insurance

Plan Name: _____ Policy/ID#: _____ Group #:_____

Subscriber's Name: _____ Patient Relationship to Subscriber: _____

Subscriber's DOB: _____ Subscriber's Employer: _____

Guarantor Information-Person responsible for payment for services rendered by Family Hearing Practice.

Guarantor Name: _____

Address: _____ Phone: _____

City, State and Zip: _____

I authorize the release of any medical or other information necessary to process my insurance claim. I also authorize payment of medical and surgical benefits to Family Hearing Practice, PLLC. **I also agree to abide by Family Hearing Practice 24 hour cancellation policy and understand that I may be charged between $35 and $100 if proper notification is not given.**

_____ _____

Signature of Patient or Guardian Date

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ADULT MEDICAL HISTORY

Patient's Name:_____ Today's Date:_____

Family Doctor:_____ Referring Doctor:_____

Address: _____ Address: _____

_____ _____

Phone Number: _____ _____

1. What is the reason for today's visit? _____
2. Will this be your first hearing test? ❑Yes ❑No
3. Have you ever had ear surgery? ❑Yes ❑No
4. Do you have any of the following:
   a. Deformity of the ear? ❑Yes ❑No b. Recent ear drainage? ❑Yes ❑No c. Ear infection? ❑Yes ❑No
5. Do you feel that your hearing is worse in one ear? ❑Yes ❑No
   a. If so, which ear is worse? ❑Left ❑Right
6. Do you experience noises or sounds in your ears? ❑Yes ❑No
7. Have you had sudden or rapid hearing loss in the past 90 days? ❑Yes ❑No
8. Have you experienced acute or recurring dizziness? ❑Yes ❑No
9. Is there a family history of hearing loss? ❑Yes ❑No
10. Do you ever have ear pain? ❑Yes ❑No
11. Have you ever found it necessary to have a doctor remove wax from your ears? ❑Yes ❑No
12. Have you been exposed to loud sounds at work or in hobbies? ❑Yes ❑No
13. Do you experience sensations of fullness in the ears? ❑Yes ❑No
14. Do you have diabetes or high blood pressure problems at this time? ❑Yes ❑No
15. Do you have any medical conditions that we should be aware of? ❑Yes ❑No

16. Do you have any of the following: ❑Diabetes ❑Hypothyroidism ❑High Blood Pressure ❑Kidney Disease

    ❑Heart Disease ❑Cancer ❑Head Trauma/Injury ❑Heart/Vascular Disease ❑Chronic Renal Disease

17. Are you on any medications? ❑Yes ❑No

    a. If so, please list:_____

18. What hearing difficulties are you experiencing? _____

19. In what situations would you like to hear better?_____

20. What would prevent you from wearing hearing aids?_____

21. How did you hear about Family Hearing Practice?_____

22. Are you a smoker? ❑Yes ❑No

2913 Corporate Circle, Suite 300, Flower Mound, TX 75028
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PATIENT PAYMENT POLICY

Thank you for choosing Family Hearing Practice for your treatment and care. We understand that medical bills can be costly and unexpected; therefore, we try to make the payment process as easy on you as possible.

Do you file to my insurance?

We file to your insurance company as a courtesy to you. We will attempt to verify your insurance benefits before each visit so that you are aware on any charges you may incur beforehand. It is important to understand that some co –insurance amounts are not able to be determined until insurance pays on a claim. Any statement you receive from our office is sent to you as a request for payment, not as a notification of insurance payment. If you are receiving a statement from our office, it is because your insurance has said that the amount owed is your responsibility. If you are questioning the bill, you may contact your insurance company directly to find out why they have applied the amount to your out of pocket expenses. You may also contact our office.

Do I need a referral?

If you have an HMO plan with which we are contracted, you may need a referral authorization from your primary care physician. Our office will attempt to obtain a referral prior to your visit, but if we have not received one at the time of your visit, you will be charged for the visit.

How may I pay?

Our office accepts payment by cash, Visa, MasterCard, American Express, and Discover. We also accept checks, but there will be a $30 charge on any returned checks for insufficient funds, and our office may seek legal action. If an account is not paid within 90 days from the date of service, a $20 service fee will be added to the total amount owed.

Do you take Care Credit?

Our office does accept Care Credit as a form of payment. Care Credit is a medical credit card that enables you to pay your bills at 0% interest, and you are able to apply in the comfort of your own ho me at CareCredit.com. If you have any questions about Care Credit or wish to sign up, please ask to speak to speak to one of our office staff.

Do you charge for Medical Records?

Our office may charge for certain medical records that are sent. Some records sent for continuing treatment are complimentary. Federal disability forms are charged $18. Complete medical records are $25, and any records being requested by law firms where we may be a witness for you in a law suit are $50.

I acknowledge that I have read, understand, and will comply with these payment policies.

Signature: _____ Date: _____

Patient, Guarantor, or Legal Guardian

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I understand that as part of my healthcare, Family Hearing Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care and treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with our healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

The Family Hearing Practice *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this consent. I understand that Family Hearing Practice has the right to change the *Notice of Privacy Practices.* Prior to implementation of the revised *Notice of Privacy Practices,* the revised *Notice* will be mailed to me if information for treatment, payment, or healthcare operations and that Family Hearing Practice is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that Family Hearing Practice has taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

I request the following restrictions on the use and/or disclosure of my protected health information:

_____

_____

I further understand that any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I give permission for my protected health information to be disclosed for purposes of communicating results, finding, and care decisions to:

Name: _____ Name: _____

Name: _____ Name: _____

(Please make sure if the patient is a minor that you have included any family members you would like for us to share information with.)

I have been provided and reviewed the Family Hearing Practice *Notice of Privacy Practices.* I understand that if I have any questions or complaints, I may contact the practice's HIPAA Compliance Officer at 817-997-4084.

Printed Name: _____

Signature: _____ **Date:** _____

If not patient, relationship to patient: _____
If you are the patient's Power of Attorney, please provide us with documentation for our records.