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

PEDIATRIC PATIENT INFORMATION

Patient Information

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient's Date of Birth: _____ Parent's Name: _____

Home Phone: _____ Parent's Date of Birth: _____

Parent/Guarantor Information (Guarantor is the person responsible for payment for service rendered by Family Hearing Practice)

Last Name: _____ First Name: _____ MI: _____

Address: (If different than Patient)_____

City, State and Zip: _____

Date of Birth: _____ Cell Phone: _____

SSN: _____ Work Phone: _____

Email Address: _____

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: _____

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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PEDIATRIC MEDICAL HISTORY

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

Pediatrician: _____ Referring Doctor: _____

Pediatrician Address: _____ Referring Doctor Address: _____

_____

Phone Number: _____ Phone Number: _____

Birth Hospital: _____

BIRTH HISTORY

1. What is the reason for today's visit? _____
2. Did the child's mother experience any complications/illnesses during pregnancy? ❑Yes ❑No
   a. If yes, please describe: _____

   _____
3. Length of Pregnancy_____Length of Labor_____Childs Birth Weight_____
4. Was the child in the NICU (Neonatal Intensive Care Unit)? ❑Yes ❑No
   a. If yes, how long was the child in the NICU? _____
5. Did your child receive oxygen? ❑Yes ❑No
   a. If yes, for how long? _____
6. Did your child receive any known medications/treatments while in the NICU? ❑Yes ❑No
   a. If yes, please list: _____
7. Please check an y conditions that were present at the time of your child's birth:

   ❑Jaundice ❑Toxoplasmosis ❑Seizures ❑Cytomegalovirus (CMV)
   ❑Breathing Problems ❑Herpes Simplex ❑Rubella
   ❑Blood Exchange ❑Hyperbilirubinemia ❑Syphilis
   ❑Other: _____

8. Please check if your child has experienced any of the following illnesses or conditions:

   ❑Allergies ❑Asthma ❑Colds ❑Tonsillitis
   ❑Headaches ❑Dizziness ❑Tinnitus ❑Sinusitis
   ❑Pneumonia ❑Convulsions ❑Croup ❑Chicken Pox
   ❑Encephalitis ❑Measles ❑Mumps ❑German Measles
   ❑High Fevers ❑Ear Infections ❑Draining Ears ❑Mastoiditis
   ❑Influenza ❑Meningitis ❑Head Injury
   ❑Other: _____

FAMILYHEARING
PRACTICE

MEDICAL HISTORY CONTINUED

1. Has your child been diagnosed with a syndrome? ( ) Yes ( ) No
   a. If so, please describe: _____
2. Has your child been hospitalized? ( ) Yes ( ) No
   a. If so, please describe: _____
3. Is your child currently on medication? ( ) Yes ( ) No
   a. If so, please describe: _____
4. Is there a family history of hearing loss? ( ) Yes ( ) No
   a. If so, please describe: _____
5. Does your child have a vision impairment? ( ) Yes ( ) No
   a. If so, please describe: _____
6. Did your child pass their newborn hearing screening at birth? ( ) Yes ( ) No
   a. If no, was follow-up testing pursued? ( ) Yes ( ) No
7. Has your child ever received a hearing test? ( ) Yes ( ) No
   a. If yes, where and what results were obtained? _____
8. Has your child ever had ear surgery? ( ) Yes ( ) No
   a. If yes, where and what results were obtained? _____
9. H as your child ever received a speech/language evaluation? ( ) Yes ( ) No
   a. If yes, where and what results were obtained? _____
10. Do you suspect that your child has a hearing loss? ( ) Yes ( ) No
11. Are you concerned regarding your child's speech production abilities? ( ) Yes ( ) No

SCHOOL INFORMATION

School Name: _____ Grade: _____

Does your child receive any special services? _____

Does your child currently have an IEP (Individualized Education Plan)? ( ) Yes ( ) No

If yes, please describe: _____

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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 your initial 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.

Cash Procedures

Certain procedures done in our office are not covered by insurance. These procedures include, but are not limited to:

- Removal of impacted ear wax
- Hearing aid programming
- Earplugs and earmolds
- Removal of foreign body from ear
- Hearing aid clean and check

I understand that I am responsible for payment for these services should I desire them and that I will provide payment at time of appointment. I will tell the audiologist at the time of my appointment if I do not wish to have these services performed.

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.

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. **Please review it carefully.**

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION:
Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment and personal demographics (i.e. address, date of birth, health insurance etc…) This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment, and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS:
Your health record belongs to you, unless otherwise required by law that it is the physical property of the healthcare practitioner or facility that compiled it. You have the right to request a restriction on certain uses and disclosures of your information, and request amendments to your health record. This includes the right to obtain a paper copy of the notice of information practices upon request, inspect and obtain a copy of your health record. Obtain an accounting of the disclosures of your health information, request communications of your health information by alternative means or at alternative locations, revoke your authorization to use or disclose health information except to the extent that actions has already been taken.

OUR RESPONSIBILITIES:
This organization is required to maintain the privacy of your health information. In addition, provide you with notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. This organization must abide by the terms of this notice; notify you if we are unable to agree to a requested restriction; accommodate reasonable requests you may have to communicate health information by alternative means or alternative locations. We reserve the right to change our practices and to make the provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, and post our new notice on our Website. We will not use or disclose your health information without your authorization, except as described in this notice.

Your health information will be used in the following ways:

- We will use your health information for treatment. Information obtained by a healthcare practitioner will be recorded in your record and used to determine the course of treatment that should work best for you. We will also provide your other practitioners with copies of various reports that should assist them in treating you.
- We will use your health information for payment. A bill may be sent to you, or a third-party payer. The information on/or accompanying the bill may include information that identifies you, your diagnosis, procedures and supplies used.
- We will use your health information for regular health operations. Staff members may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.
-

- We may disclose some of your health information to our Business Associates (i.e. hearing aid manufactures or ear mold labs) so that they can perform the work required. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.
- We may use or disclose information to notify or assist in notifying a family member, personal representative, or other person of your care, your location and/or general condition.
- We may disclose to a family member, other relatives, close personal friends or any other persons you identify, health information relevant to that person's involvement in your care or payment related to your care.
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and/or services that may be of interest to you.
- As required by law, we may disclose to the FDA health information relative to adverse events with respect to product defects, or post marketing surveillance information to enable product recalls, repairs or replacements.
- We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, such as the Division of Rehabilitative Services.
- As required by law, we may disclose your health information to public health or legal authorities charged with tracking birth and deaths, as well as with preventing or controlling disease, injury or disability.
- Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals. An inmate does not have the right to the Notice of Privacy Practices.
- We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provide that a work force member or business associate believe in good faith that we engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.
- We will use your contact information to send appointment reminders and other office notification.

IDENTITY THEFT PREVENTION AND DETECTION:

It is the policy of this practice to follow all federal and state laws in protecting your private information and reporting requirements regarding identity theft as per the Red Flag Rules compliance program. To protect your identity HPI will ask for the following in order to protect you:

- Driver's license or other type of photo ID
- Current health insurance card
- Utility bill or other correspondence showing current residence if your photo ID does not show a current address

Should HPI suspect fraudulent activity (a red flag), HPI reserves the right to:

- Cancel the transaction
- Contact the appropriate enforcement
- Notify the affected person
- Notify affected physician(s)

This notice will be prominently posted in the office where registration occurs. Patients will be provided a hard copy, if requested, and the notice will be maintained on our Website.

FOR MORE INFORMATION, OR TO REPORT A PROBLEM:

If you have questions and would like additional information, you may contact Family Hearing Practice, PLLC at 817-997-4084. If you believe your privacy rights have been violated, you can file a complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.