Center for Audiology

Pediatric Information and History Form

Please complete all information. If not applicable, write N/A. Present all insurance cards to the receptionist.

PLEASE PRINT

Reason for visit? _____

How did you hear about our office or Referring Provider? _____

Who is accompanying the patient today? _____ _____
Name Relationship to Patient

_____, _____, ____ _____ _____
Last Name First Name Mi. Preferred Name Date of Birth

_____ _____ _____ _____
Address City State Zip

(_____)_____ (_____)_____ Circle Gender: Male Female
Contact Phone # Alternate Phone #

_____
Parent (or Legal Guardian) Name Parent/Guardian Date of Birth Parent/Guardian Social Security #

_____ _____
Parent/Guardian Email Address Name of Patient's Pediatrician

_____
Emergency Contact Name, Relationship, & Phone Number (Not living in your home)

Did your child have a Newborn Hearing Screening? Yes No Unknown **Result:**_____

Birth Hospital? _____

Does your child receive speech services? Yes No **Facility:**_____

Please list or provide a list of current medications: _____

Check all that apply to the patient:

- ☐ Family Hearing Loss
- ☐ Prematurity
- ☐ Low Birth Weight
- ☐ Infection at Birth
- ☐ NICU Stay
- ☐ Cleft Lip or Palate
- ☐ Frequent Ear Infections
- ☐ Trauma to the Head
- ☐ Ear Surgery
- ☐ Other Developmental Delay
- ☐ Speech or Language Delay
- ☐ Cancer
- ☐ Measles, Mumps, or Meningitis
- ☐ Diagnosis of Genetic Disorder
- ☐ Other: _____

Center for Audiology, P.C.

Patient Name _____

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

I acknowledge full financial responsibility for services rendered by the Center for Audiology. I understand that I am responsible for prompt payment of any amounts due including, but not limited to: co-payments, deductibles, and coinsurance amounts. I understand that without health insurance coverage, services rendered must be paid in full at time of service. A $25.00 charge will be added to my account for each returned check. I agree to pay all costs of collection activity including attorney fees, collection fees, court costs, skip tracing costs, and contingent fees to collection agencies for any delinquencies on my account (30-50% of billed charges). All insurance information must be provided and verified before services are rendered. If my insurance coverage is unable to be verified, I will be responsible for all charges at the time of service. I acknowledge I must keep my account current and up to date by notifying the office of any address or insurance changes as they occur. I consent that payment of authorized Medicare and other insurance benefits may be made on my behalf directly to the Center for Audiology for any services or products furnished.

Patient or Guardian Signature _____ Date_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

The Center for Audiology's Privacy Practices provide detailed information about how your confidential protected health information may be disclosed and your rights to your protected health information. The Privacy Practices are available at the reception counter, posted in the waiting room, and available on-line. I understand that Center for Audiology reserves the right to change its privacy practices without advanced notice. I hereby acknowledge I have read, understand, and agree to the terms therein. Any questions pertaining to this information have been discussed with staff before signing.

Patient or Guardian Signature _____ Date_____

CONTACT PERMISSIONS

I authorize Center for Audiology to contact me by the following methods:

Yes	No	
☐	☐	**Phone Calls & Voice Messages**
☐	☐	**Third Party Mailings** *(i.e. Information and Materials from Partnering Businesses)*
☐	☐	**Text Messages #_____**
☐	☐	**Emails _____**
☐	☐	**I wish to sign a form allowing another individual access to my confidential medical record information** *(i.e. Spouse, Child, Grandparent)* **Note: Custodial parents have automatic access to child's record**

Patient *or* Guardian Signature _____ Date_____

If you are not the patient, specify your name _____ & relationship to patient _____

Center for Audiology
1740 Memorial Drive, Suite 1
Clarksville, TN 37043
Phone (931) 645-3937
Fax (931) 645-1043
www.ClarksvilleCFA.com

NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices is required by the Privacy Regulations stemming from the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **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.**

This practice is determined to protect the privacy of your medical information. As we provide service to you, we create and store health information (a medical record) that identifies you. It is often necessary to share or disclose this health information in order to provide treatment for you, to obtain payment, and to conduct healthcare operations in our office.

This Notice of Privacy Practices requires us to:

1. Keep your medical records private and provide you with this notice.
2. Update our privacy practices and the terms of this notice at any time, ensuring our notice is effective, even for information recently obtained.

We reserve the right to make an important change in our privacy practices and change this notice to that effect. You may contact us to request a new copy of our notice and we will make the new notice available upon request.

The following are descriptions of the different circumstances that may require our practice to use or disclose your medical information.

1. Sharing medical data with another provider who is responsible for your care (physicians, audiologists, nurses, other healthcare professionals, technicians, students in healthcare, or any other people who take care of you), making referrals, and/or placing lab/prescription orders.
2. Sharing with your health insurance plan information about a treatment you received at our practice when filing a claim for reimbursement or determination of benefits.
3. To business associates to perform functions on our practice's behalf, if the business associate has signed an agreement to protect the confidentiality of the information.
4. Sharing information about your condition(s), location, and/or death with family member(s) or your personal representative(s). Prior permission from you will be obtained unless in case of emergency. If we are unable to obtain permission, we will share only the health information directly necessary for your health care.
5. Provide treatment communication concerning treatment alternatives or other health-related products or services, unless we or a business associate receive financial remuneration in exchange for the communication, in which case we must receive your written authorization, unless the communication is made face-to-face or involves gifts of nominal value.
6. Disclosing medical information to a medical examiner to identify a deceased person or to determine the cause of death, or for tissue donations.
7. Medical information may be disclosed if you are military personnel, either active or veteran, and if required by the appropriate authorities.
8. Sharing medical data with the public health and/or law enforcement official whose job it is to prevent or control disease, injury or disability.
9. Sharing medical data with a representative from the Food and Drug Administration for the purpose of reporting adverse effects stemming from defective products, etc.
10. Medical information may be disclosed when necessary to comply with workers' compensation.
11. Medical information may be disclosed in response to a court and/or administrative order in a lawsuit or similar proceeding.
12. In order to contact you for fundraising activities supported by our practice. You have the right to opt out of receiving these communications by signing a Privacy Permission Form.
13. For marketing purposes for which our practice or our business associates may receive remuneration, for a disclosure that constitutes a sale of protected health information, and in all other situations not described in this policy, your written authorization will be obtained before our practice will use or disclose your health information to third parties outside our practice. You have the right to revoke such authorization by providing our practice with a written request to revoke the specific authorization or by signing a Privacy Permission Form.
14. If a use of disclosure is required by law, the disclosure will be made in compliance with the law and will be limited to such requirements. State and federal laws may be more stringent and may prohibit certain uses and disclosures identified above. When another law is more stringent than HIPAA, we will follow more stringent requirements.

You have individual rights as part of the Notice of Privacy Practices. As a patient of an Audigy Certified practice, you have the right to:

1. Request that our practice restrict uses and disclosures of your health information. However, we are not required to agree to the requested restriction unless you are requesting a restriction on the use and disclosure of your protected health information to a health plan for payment or healthcare operations and such information pertains to a healthcare item or service which you paid for in full or out of pocket. These requests should be made in writing to the address given in this privacy notice. In your request, you must tell us (a) what information you want to limit; (b) whether you want to limit our use, disclosure, or both; (c) to whom you want the limits to apply.
2. Be notified upon a breach of any of your unsecured protected health information.
3. Request that we communicate with you regarding your confidential medical information by different means or at different locations. This request must be made to our practice in writing.
4. Request photocopies of your medical records on file and/or a copy of this Notice of Privacy Practices. If you need a photocopy, please notify the receptionist.
5. Request a change to your health information if you think it is incomplete or inaccurate. However, if the audiologist, hearing care professional, or office personnel believe the patient's health information is complete and accurate, he/she can refuse to make the requested changes. This request must be made in writing to your Audigy Certified practice.
6. Receive a list of all the times your medical information has been shared by our office or our business associates for six years prior to the request date, other than treatment, payment, healthcare operations, and/or other specified exceptions.
7. Request a paper copy if you have received this Notice of Privacy Practices electronically. This request must be made in writing to your Audigy Certified practice.

This notice is effective as of August 2013 and is revised annually.

According to HIPAA regulations, you have the right to restrict the uses or disclosures of your information made for purposes of treatment, payment, and/or healthcare operations.

- Treatment is the provision, coordination, or management or hearing health care. For example, we may use and disclose your information to consult with a third party or to refer you to other healthcare providers. We will get your written consent prior to making disclosures outside our practice for treatment purposes, except in emergencies.
- Payment includes the activities necessary to obtain reimbursement for the provision of hearing healthcare. For example, we may need to give your health plan information about treatment you receive at our practice so your health plan will pay us or reimburse you for the treatment. We will get your written consent prior to making disclosures for payment purposes.
- Healthcare operations include the activities necessary for our practice to run its business operations. For example, we may use your information to review treatment and services and to evaluate the performance of our staff.

If you have any questions regarding our privacy practices or think we may have violated your privacy rights, please contact us at:

Center for Audiology
1740 Memorial Drive, Suite 1
Clarksville, TN 37043

If your concern is not resolved, you may also submit a written complaint to the U.S. Department of Health and Human Services. If you choose to file a complaint, we will not retaliate in any way.

Audigy Certified Professionals are among the country's most experienced practitioners of hearing aid diagnostic services. We have been certified by Audigy Group, the largest member-owned organization in the hearing care industry. Audigy Group's purpose is to strategically select and certify the most elite practitioners in each market who exemplify the core values of Audigy's mission and vision in the delivery of hearing and diagnostic services.

Our shared mission is to deliver:

- Effective analysis and diagnosis of your hearing loss or balance condition
- Customized technology solutions that effectively integrate speech comprehension back into your life
- Unsurpassed patient satisfaction
- Excellence through continuing education
- Ongoing investment in the most advanced processes, procedures, and technology to ensure superior results for each patient.

Our practitioners understand "value" is not measured by price alone. Rather, value is in how well they utilize their knowledge and experience to create a customized solution to meet your hearing expectations and your lifestyle.

CENTER FOR AUDIOLOGY PERSONAL REPRESENTATIVE FORM

Name of Patient	Patient Date of Birth	Patient Contact Phone #
_____	_____	_____

You have the right to appoint a family member or friend access to, a portion, or all of your protected health information. This action does not restrict your rights to your own personal health information; it merely allows someone of your choosing to have access as well. You do not have to appoint a representative.

I hereby authorize Center for Audiology to disclose my protected health information (as described below) to the individual(s) named below. I understand that the protected health information released to the individual(s) named below may be further disclosed by the recipient and no longer protected by Federal law.

CHOOSE AND INITIAL ***ONE*** STATEMENT:

_____ (initial) I hereby authorize Center for Audiology to disclose ***ALL*** of my protected health information to my personal representative. This information will include clinical information about my care, billing information related to my health insurance coverage and payment activity for services rendered by Center for Audiology. The representative may also make demographic changes to my account. By choosing this option, I understand that my personal representative will have the same access as I do to my medical records and health data.

OR

_____ (initial) I hereby authorize Center for Audiology to disclose ***ONLY*** the protected health information listed below. By choosing this option, I understand that my personal representative will only have access to the specific portion(s) of my medical records:

_____

(Example: billing information only, test results only, treatment notes, etc…)

Representative's Full Name	Representative's Birthdate	Representative's Contact Phone #
1.) _____	_____	_____
2.) _____	_____	_____
3.) _____	_____	_____

I understand that except to the extent that action has been taken based on my authorization, I may revoke this authorization at any time by written notification to Center for Audiology, Attn: Privacy Officer
Center for Audiology
1740 Memorial Drive, Suite 1
Clarksville, TN 37043

Center for Audiology will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on my provision of this authorization unless the authorization was for research related treatment and information disclosure, or the treatment is solely for the purpose of disclosing to another individual or business. I understand that I may refuse to sign this authorization and that Center for Audiology will not retaliate against me if I refuse to do so. I understand I have the right to receive a copy of this authorization.
I understand that Center for Audiology reserves the right to request proof of identity of representatives for verification purposes.

Signature of Patient, Guardian, or Power of Attorney_____

Guardian or Power of Attorney **Printed Name** _____

Date _____

Center for Audiology Policies

Late Policy

Our office adheres to a grace period of 10 minutes past the scheduled appointment time **only**. This ensures adequate time to obtain a medical history, perform necessary services such as full comprehensive hearing testing, hearing aid fittings, or hearing aid reprogramming services, as well as time to provide counseling and answer additional patient questions. Patients who do not show for their appointment may be charged a no-show fee of $25.00, which is not covered by health insurance.

Additional Children Policy

No children are to attend appointments unless they are the scheduled patient. This is to ensure that minimal distractions occur during the appointment and that the scheduled patient receives our full attention and medical care.

Food & Beverage Policy

Food and beverages are restricted inside the building.

Termination Policy

As our office strives to provide the best care possible to our community, we must set boundaries in order to provide reasonable appointment times and equal rights to all patients. Clinic termination will occur under the following conditions:

- Accumulation of THREE missed, same-day reschedule, or same-day cancellation appointments
- Displaying non-compliant or inappropriate behavior towards staff
- Failure to uphold financial obligations as per signed agreements

Payment Policy

This office contracts with a wide variety of health insurances. As a courtesy, our office attempts to obtain eligibility and benefits for each scheduled patient. Copays, deductibles, co-insurances, and out of pocket estimates are due at time of service. Any additional balances or credits will be addressed after insurance explanation of benefits are received. After THREE unpaid mailed statements, accounts may be forwarded to a collection agency. No further appointments will be scheduled until full payment is received.

Refund Policy

All refunds will be issued via the original payment method (personal check or credit card). Credit card refunds must be issued to the same card used. If the original card is no longer available, a check refund will be issued for the refund amount minus a 5% service charge.