Welcome to our Office

Lorin S. Oden, AuD, FAAA
Doctor of Audiology
Hearing Solutions of North Carolina, PLLC
Ph.: 704-633-0023 Fax: 704-705-2363
464 Jake Alexander Blvd., West • Salisbury, NC

Patient Name____ (________________)
FIRST MI LAST PREFERRED NAME

Address____

City _____________________ State ______ Zip Code ______________ Male ☐ Female ☐

Date of Birth _______//________//_____________ Age ________ SS# ______________________

Home Phone ______________________Work Phone ______________________ Cell ______________________

Email Address: ______________________________

Employer ______________________________Work Ph. ________________ Cell Ph.__________________

Marital Status: Single ____Married ____Divorced ____Widowed____ Spouse's Name: ______________________

Primary Care Physician______________________________ City ______________ Phone (________________)

Reason for Today's Visit ____

Emergency Contact ______________________________ Phone: ____________Relationship:______________

Primary Insurance __________________________ Secondary Insurance __________________________

Policy Holder's Name______________________________ Policy Holder's Date of Birth ______________________
(If other than patient) (If other than patient)

.

How Did You Hear About Us? ☐ Salisbury Post/Weather ☐ Senior Savvy ☐ Physician ☐ Insurance
☐ Website ☐ Internet ☐ Friend/Family ______________________________

Others Accompanying Patient____________________________________ Relationship: ________________

So that we may serve you better, please provide us with the name(s) of the person(s), with whom we may discuss your health information; for the purpose of: Picking up hearing aids and/or supplies, assisting in care, scheduling appointments, and general information.

Name ______________________________________ Relationship ____________________________

Name ______________________________________ Relationship ____________________________

Yes ____ No _____ May we remind you of your appointments and/or leave a detailed message on your: home, cell, work, voice mail or e-mail address?

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I received a copy of Hearing Solutions of North Carolina, PLLCs' Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area and the website and that any revised Notice of Privacy Practices will be made available. I have read all the information on this form and certify that this information is correct to the best of my knowledge. I will notify Hearing Solutions of North Carolina, PLLC of any changes in my health status or in the above information.

☑ ____ ____________________________
Signature of Patient or Responsible Guarantor **Date**

Patient Authorization

Patient Name: ____

Date of Birth: __________________________________

Release of Information & Consent for Treatment

All information provided herein is true and correct.

I am aware of my diagnosis and wish to receive treatment at Hearing Solutions of North Carolina, PLLC. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include evaluation, testing and treatment. No guarantees have been made to me concerning the outcome of this care.

I give permission to Hearing Solutions of North Carolina, PLLC and/or its affiliates to release information verbal and written contained in my medical record, and other related information, to persons, and companies as it relates to my treatment and/or payment for services provided. I authorize Hearing Solutions of North Carolina, PLLC and /or its affiliates to obtain medical records and/or professional information from my physician or other medical professionals as it relates to my treatment.

My initials below certify that I have read and understand the above information.

Initial: ___________

Assignment of Benefits

I authorize for services or goods provided to me to be billed on my behalf by Hearing Solutions of North Carolina, PLLC or its affiliates. I authorize payments for these goods and services to be released directly to Hearing Solutions of North Carolina, PLLC or its affiliates. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original. I understand that I am responsible for any copays and deductibles.

Initial: ___________

Notice of Privacy Practices (HIPAA Acknowledgment/Consent)

I hereby acknowledge that I have been offered a copy of The Notice of Privacy Practices for Hearing Solutions of North Carolina, PLLC and/or its affiliates. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations.

Initial: ___________

Payment Guarantee

I agree to pay Hearing Solutions of North Carolina, PLLC and/or its affiliates for the services provided to me or the patient named above. If any law, such as Worker's Compensation, or insurance contract prohibits payment for these services, I will cooperate and assist in the provision of information, authorizations, releases or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances. If collection or legal action is required to collect a debt, you are responsible for any fees associated with the effort.

The benefits verification information is only an explanation of coverage obtained from my insurance company and is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment of these services. I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Hearing Solutions of North Carolina, PLLC and/or its affiliates.

Patient/Guardian Signature: ____ **Date:** _________________________

464 Jake Alexander Blvd., West•Salisbury, NC 28147•Ph:(704)633-0023•FAX:(704)705-2363

Patient Case History Date Completed: ________________

Name: ____ Preferred Name: ________________

Name of person accompanying you for this appointment: ____________Relationship: ________________

Reason for today's visit.____

How did you find out about our services? ____

Please check those that apply

__________ Experiencing hearing or understanding difficulty
__________ Congenital or traumatic deformity of the ear
__________ History of active ear drainage within the past 90 days
__________ History of sudden or rapidly progressive hearing loss within the past 90 days
__________ Dizziness within past 90 days
__________ Hearing loss in one ear of sudden or recent onset within the past 90 days
__________ Pain or discomfort in the ear within past 90 days
__________ Tinnitus or ringing in the ear(s): Onset within the past 90 days
Describe Tinnitus: Ringing___Hissing___Crickets__Music__Voices__Other__________
____
__________ Long standing history of Tinnitus:
Describe Tinnitus: Ringing___Hissing___Crickets__Music__Voices__Other__________
__________ History of noise exposure: Current_____Past_____Work related______Recreational______
__________ Use hearing protection: Type: ____
__________ Exposure to work related chemicals or solvents: Describe___________________________
__________ Have been diagnosed with temporomandibular joint dysfunction (TMJ)
__________ Wear a night guard for TMJ
__________ Intake of caffeine: Quantity/Type____
__________ Use of artificial sweeteners: Type____
__________ Nicotine use
__________ Exercise: Describe____
__________ Family history of hearing loss: Who____
__________ Currently have hearing instruments: For how long_______________________________
Condition of current hearing instruments______________________________________
__________ Excessive perspiration
__________ Excessive cerumen or wax in ears
__________ Diagnosed with: Diabetes_______Hypertension______Thyroid Problems________

Current Medications: Reason you take them

_________________________________ ____

_________________________________ ____

_________________________________ ____

Office Note: _______________

Hearing and Communication Questionnaire

Name: ____ DOB: ____________________ Date: ________________

Thank you for answering these questions. Your responses will assist us in providing you with the best hearing healthcare. Our goal is to maximize your ability to hear so that you can more easily communicate with others. By completing this form we will have a better understanding of your hearing needs.

Please complete the following. Be as honest as possible. Be as precise as possible.

1. List the top three situations where you would like to hear better. Be as specific as possible.

   ____

2. If we find you need help, how motivated are you to wear and use hearing aids? Mark an X on the line.

   Not Very Motivated 1 -- 10 *Very Motivated*

3. How well do you think hearing aids will improve your hearing? Mark an X on the line.

   Not helpful at all 1 -- 10 Greatly *improve my hearing*

4. On a scale of 1 to 10, 1 being the worst and 10 being the best, how would you rate your ability to understand speech.

   Worst 1 --------2--------3-------4--------5-------6--------7--------8--------9-------- 10 *Best*

5. What is your most important consideration regarding (new) hearing aids? Rank the following factors with 1 as the most important and **4** as the least important.

   _____ Hearing aid size and the ability of others not to see the hearing aids

   _____ Improved ability to hear and understand speech

   _____ Improved ability to understand speech in noisy situations (e.g., restaurants, parties)

   _____ Financial Investment of hearing aids

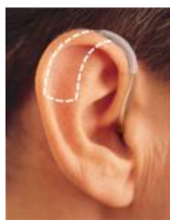
6. Do you prefer hearing aids that: (check one)

   ___ are totally automatic so that you do not have to make any adjustments to them

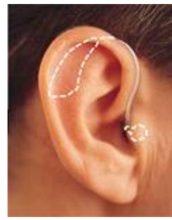
   ___ allow you to adjust the volume and change the listening programs as you see fit

   ___ no preference

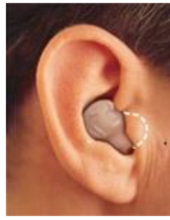
7. Look at the pictures of the hearing aids. Please place an X on the picture(s) of the style(s) you would **NOT** be willing to use. We will discuss with you, if your choices are appropriate for you – given your hearing loss and physical shape of your ear.



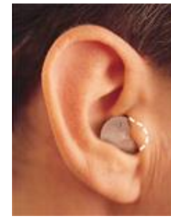
BTE



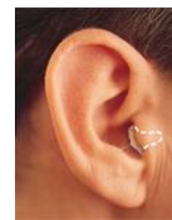
Mini BTE



In the Ear



In the canal



CIC

8. Do you own any of the following: _____ IPhone _____IPad _____IPod

9. The ranges listed below are for ***TWO*** hearing aids. Please check the category that represents the maximum amount you are willing to invest. Please understand that you are not locked into that price range. It is just very helpful for us to know your budget so that we can provide you with the most appropriate hearing aids.

   ___ Premium digital hearing aids: from $6900.00 to $7900.00* *Includes supplies, maintenance,
   ___ Mid-level digital hearing aids: from $5400.00 to $6400.00* quarterly complimentary cleanings
   ___ Standard digital hearing aids: from $3900.00 to $4900.00*
   ___ Basic digital hearing aids: from $2100.00 to $2900.00 (supplies/maintenance not included)

We offer 12 month no interest financing. Please check if interested. Yes ____ No ____

Hearing Solutions of North Carolina, PLLC
Policy Information

Thank you for placing your confidence in our staff. If you need assistance regarding your bill, call our office between 8:30am and 4:00pm, Monday through Thursday at 704-633-0023.

Appointment Scheduling

- Please notify our office as soon as possible if you need to reschedule or cancel your appointment; failure to do so will result in a $20.00 no show fee.
- If you arrive more than five (5) minutes late for your appointment, you may need to reschedule so as not to inconvenience the remainder of the patients on that day's schedule.
- Excessive abuse of missed appointments may result in discharge from the practice.

Payment Policy

- Payment is due at time of service.
- Co-pays, deductibles, co-insurance and previous outstanding balances are due before additional services are received.
- We accept cash, checks, and credit cards. We also offer interest free loans through World Financial.
- There is a service charge for returned checks.

Billing

- We will bill your insurance for the services and treatments rendered. If problems arise you may be asked to help resolve the billing issue with your insurance provider.
- If payment is not received by your insurance provider within 45 days, the balance will become your responsibility.
- Please pay balance upon receipt of your statement. Any unpaid balance will be sent to a collection agency.
- In the event of default in payment or legal action, you will be responsible for any collection fees or court costs.

Services and Treatments

- Most insurance providers, as well as Medicare, do not cover the cost of hearing devices.
- If you have hearing instrument insurance benefits, and the purchase price of the hearing instruments you have chosen is beyond coverage provided by your insurance, you agree to pay the entire amount unpaid by your insurance company.

Refunds

- Account credits less than $20.00 will be retained and credited toward future account balances unless a written request for a refund is received.
- Account credits greater than $20.00 will automatically be refunded.

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.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of evaluations will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer or governmental program, or from your credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of the company. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to improve quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies, without permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Uses and Disclosures Require Your Authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect, under any circumstances, our use or disclosure of information before you notify Hearing Solutions of North Carolina, PLLC of your decision.

ADDITIONAL USES OF INFORMATION

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition or new technology that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

YOUR HEALTH INFORMATION RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restriction on the use and disclosure of your health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your health information.
- The right to amend and/or submit corrections to your health information.
- The right to know how your health information has been used and to whom it has been disclosed.
- The right to receive a printed copy of this notice.

OUR HEALTH INFORMATION DUTIES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

OUR RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. The revised policy and practices will be applied to all protected health information that we maintain and will be available at our facility for you upon request.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

As permitted by federal regulation, we require that request to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the company's privacy officer.

COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, or if you believe your privacy rights have been violated, you can contact the company by sending a letter outlining your concerns to:

Privacy Officer
Hearing Solutions of North Carolina, PLLC
464 Jake Alexander Blvd., West
Salisbury, NC 28147

You may also file a written complaint with the Office of Civil Rights.