



195 S. Main Street, Suite 8 • Longmont, Colorado 80501
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 www.longmontheating.com

D'Anne Rudden, Au.D., CCC-A
 Doctor of Audiology • Board Certified by the American Board of Audiology

Patient Registration Form

Name _____ Date _____

DOB ____/____/____ Phone # _____ Home Cell

Mailing Address _____

How would you like us to communicate with you? (Select all that apply) Phone Email: _____ Text

Emergency Contact _____ Phone # _____

Primary Care Physician _____ Phone # _____

Referred By _____ Phone # _____

Would you like us to send a report to your primary care physician? Yes No

How did you hear about us?

<input type="checkbox"/> Referred by Physician	<input type="checkbox"/> Referred by a Patient/Friend	<input type="checkbox"/> Google or Internet Search
<input type="checkbox"/> Our Website	<input type="checkbox"/> DEX, YellowBook or WhitePages	<input type="checkbox"/> Newspaper Ad
<input type="checkbox"/> Received a Mailer	<input type="checkbox"/> Insurance Provider Referral	<input type="checkbox"/> Other:

PRIMARY Insurance: _____ SECONDARY: _____

Please provide the most current Primary and Secondary Insurance cards and a Photo ID to our Patient Experience Coordinator so copies can be made for your patient record and for billing purposes.

Person responsible for payments: _____ DOB: _____

If patient is under 18, a responsible party must complete this section:

Name of Responsible Party: _____

Address (if different from patient) _____

Phone # _____

HIPAA – Authorization for the Use or Disclosure of Protected Health Information (PHI)

I consent to the use or disclosure of my PHI (including audiograms) by Longmont Hearing & Tinnitus Center (Provider) for the purposes of diagnosing and/or providing hearing care and treatment to me. I understand that diagnosis of me by Provider may be conditioned by my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my PHI is used or disclosed to carry out hearing care and treatment. Provider is not required to agree to the restrictions that I may request, however, if provider agrees to a restriction that I request, that restriction is binding to Provider. I have the right to revoke this consent, in writing, at any time, except to the extent that Provider has already taken action in reliance on this consent. "PHI" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a healthcare clearinghouse. This PHI relates to my past, present or future physical and mental health and condition and identifies me, or there is reasonable basis to believe the information may identify me. I consent to Provider's use or disclosure of my PHI for purposes of delivering relevant product and/or technology marketing communication to me. I acknowledge that Provider may receive financial remuneration from the manufacturer in connection with such communications. In accordance with the requirements of the federal regulations regarding "HIPAA Privacy Rule," I have been given the opportunity to review Provider's privacy practices. I understand that should I request it, a printed copy will be provided to me. Due to the details and length of the Notice of Privacy Practices, Provider has elected to mail copies to all existing patients. Copies are available at the front desk from our Patient Experience Coordinator, or you can request to speak to our Privacy Official if you have further questions. The Privacy Rule portion of the HIPAA regulation requires our practice to submit a copy of this notice to each patient, both existing and new. If you refuse to sign this acknowledgement of receipt, Provider is not obliged to treat the patient.

 Signature of Patient or Personal Representative

 Date

Medical & Audiological History

Name _____

Date _____

What medications are you currently taking? (A list of current medications may also be provided)

Have you had any recent hospitalizations or surgeries? Yes No

If Yes, please describe: _____

Have you ever had any surgeries on or around your ears? Yes No

If Yes, please describe: _____

Do you clench or grind your teeth? Yes No

Do you have any dizziness or balance problems? Yes No

If Yes, please describe: _____

Do you have a history of ear disease? Yes No

If Yes, please describe: _____

Is there a family history of hearing loss under the age of 50? Yes No

Do you have a history of loud noise exposure? Yes No

If Yes, please describe: _____

Have you ever had wax removed from your ears? Yes No

If so, how recently? _____

Have you worn hearing aids before? Yes No

If so, how long have you worn them? _____

Are you having any difficulties with them? _____

Do you use a particular ear on the telephone? Yes No

If yes, which ear? Right Left

Do you currently have any of the following symptoms? If so, please indicate in which ear you have experienced it.

Symptom	Yes	No	Right Ear	Left Ear
Sudden or rapid hearing loss in the last 90 days				
Drainage from either ear in the last 90 days				
Difficulty hearing with either ear				
Fullness or stuffiness in either ear				
Noise in either ear				
Pain in either ear				
Deformity of either ear				

Social History

Do you use tobacco? Never Former Smoker Less than 1 pack per day 1-2 packs per day
 More than 2 packs per day Oral Tobacco

Do you use alcohol? Never Rarely Socially (1-2 drinks/week) Moderately Heavily

Do you use marijuana? Yes No If so, how much and how often? _____
 Delivery method (check all that apply): Ingested (Edibles or Tinctures) Smoked Other

Do you use recreational drugs? Yes No

Physical History

Please check, indicating yes, if you have any of the following conditions or symptoms.

Constitutional

- Recent weight gain
- Recent weight loss
- Other: _____

Neurologic

- Stroke/CVA
- Migraines
- Other: _____

Cardiac

- Congestive Heart Failure
 - Heart Attack
- High Blood Pressure
 - Pacemaker
- Heart Valve Disease
- Other: _____

Endocrine

- Diabetes
- Low Thyroid
- High Thyroid
- Other: _____

Skin

- Rash
- Eczema
- Other: _____

Musculoskeletal

- Arthritis
- Other: _____

Infectious Disease

- Hepatitis A/B/C
- Tuberculosis
 - Measles
 - Mumps
- Other: _____

Psychological/Emotional

- Depression
 - Anxiety
- Bipolar Disorder
- Recent increase in stress
- Other: _____

Cognitive Changes

- Dementia
- Alzheimer's
- Other: _____

Blood/Immune System

- Easy Bleeding
 - Anemia
 - Cancer
 - Lupus
 - HIV/AIDS
- Other: _____

Other

- Liver disease
- Visual impairment
- Poor dexterity in hands
- Changes in taste/smell
- Sinus pain/infections



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Financial Policies

Please **read, initial** to the left and **sign** at the bottom, indicating your understanding and acknowledgement of the following information. If you have any questions, please do not hesitate to ask. It is important that you understand these specific policies of the Longmont Hearing & Tinnitus Center (LH&TC), and that you understand how your insurance company will handle your claims.

_____ **It is my responsibility as the patient to provide the office with current and correct insurance information.** Failure to do so could result in my insurance company rejecting my claims for failure to obtain authorization or timely filing. In the event that this should happen, I will be responsible for the incurred charges.

_____ **It is my responsibility to verify my coverage and adhere to the restrictions of my insurance plan.** LH&TC participates with most major medical insurance companies. However, these companies frequently specify the time frame in which patients can be seen and the coverage widely varies among groups and payers. If appointments are made that are not covered by my insurance plan, I am responsible for the professional charges.

_____ **LH&TC will not always know if I have a deductible, if my deductible has been met, or if I have co-insurance.** It is my responsibility to know this information. I am responsible for all charges that are not paid by my insurance company, including those applied to my deductible or co-insurance.

_____ **Discounts are offered on some medical services, but only if I pay at the time of service.** If I have no insurance, or if I am receiving services that are not covered by my insurance plan, I may be eligible for a discount on select services. I understand that payment must be made at the time of service for the discount to apply.

_____ **If I have a copay, I understand that I am expected to pay this when I check in for my visit.** Most insurance companies assign a copayment to me, the patient, and it is the responsibility of LH&TC to collect this at the time of service. I understand I may pay by check, cash, Visa, Mastercard or Discover. I will be prepared to pay my copay when I check in for a visit.

_____ **I may be charged ½ of the predicted charges if I fail to show up to my appointment** or if I cancel my appointment within 24 hours of the scheduled time. Exceptions may be made for inclement weather. I understand I can call the office at any time at (303)651-1178 to cancel or reschedule an appointment at least 48 hours in advance.

Assignment of Insurance Benefits

Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment or your claims, or accept responsibility for negotiating claims with your insurance company. As a courtesy, we will be happy to help you determine the coverage available to you through your plan. It is important that you provide us with your current insurance information. Without a copy of your insurance card, we unable to file a claim. In this event, it will be your responsibility to file the claim privately.

_____ I hereby assign all medical benefits - including major medical benefits to which I am entitled, private insurance and any other health claims to LH&TC. A photocopy of my insurance card and driver's license are considered to be valid as an original. I am financially responsible for all charges whether paid or unpaid by my insurance plan. I hereby authorize LH&TC to release all information necessary to secure payment for their services. If insurance pays only a portion or fails to make payment at all to LH&TC within 90 days, I will be responsible for payment of the balance in full at that time.

_____ I request payment of authorized Medicare benefits to be made to LH&TC for any services rendered. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents. LH&TC is authorized to provide any information needed to determine these benefits or related services to pay the claim. If there are other insurance carriers, my signature authorizes the release of information to these companies for the purposes of processing claims. In Medicare-assigned cases, LH&TC agrees to accept the charge determination of the carrier as the full charge, and I am responsible for only the deductible, coinsurance and non-covered services, based upon the charge determination by the Medicare carrier.

Signature: _____

Date: _____