HANOVER AUDIOLOGY, PLLC

7484 Lee Davis Road, Suite 10 ~ Mechanicsville, VA 23111
(804)789-1764 [Main] ~ (804) 789-1762 [FAX]

PATIENT INTAKE INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Cell Phone: _____ Primary Phone (***check one***): ☐ Home ☐ Cell

E-mail Address: _____

Is it okay for us to (choose **ALL** acceptable options): ☐ Call ☐ Leave a Message ☐ Send E-mails ☐ Text Message Reminders

Employer (*if applicable*): _____

Occupation: _____ Work Phone (*if applicable*): _____

Marital Status (*choose one*): ☐ Single ☐ Married ☐ Divorced ☐ Widowed

EMERGENCY CONTACT

Emergency Contact Name: _____ Phone Number: _____

Relationship to Patient: _____

PRIMARY CARE PHYSICIAN INFORMATION

Physician's Name: _____ Phone Number: _____

Address: _____ City/State: _____ ZIP Code: _____

INSURANCE

*Upon arrival to your scheduled appointment, please provide insurance card(s) and identification to our patient care coordinator. However, **if the policy holder is someone other than the patient,** please complete the following section:*

Policy Holder Name: _____ Policy Holder Date of Birth: _____

AUDIOLOGICAL/MEDICAL HISTORY

☐ YES ☐ NO Have you ever had your hearing evaluated before? If so, when? _____

Which ear is your best ear? ☐ RIGHT ☐ LEFT ☐ BOTH THE SAME

☐ YES ☐ NO Have you experienced a sudden/rapid progressive hearing loss within the past 90 days?

☐ YES ☐ NO Have you had any active drainage from either ear within the past 90 days?

☐ YES ☐ NO Have you experienced any ear pain or discomfort in either ear within the past 90 days?

☐ YES ☐ NO Have you experienced any recent (acute) or long-term (chronic) dizziness?

☐ YES ☐ NO Do you current (or previously) have chronic ear infections? If so, describe: _____

☐ YES ☐ NO Have you seen a physician(s) regarding your ears? If so, who? _____

☐ YES ☐ NO Have you received medical and/or surgical treatment for hearing loss?

☐ YES ☐ NO Have you ever suffered a concussion, trauma, or blow to the head? If so, describe: _____

☐ YES ☐ NO Have you been exposed to loud or excessive noise? If so, describe: _____

_____

☐ YES ☐ NO Do you currently experience ringing (tinnitus), noises, or sounds in your ears or head? If so, describe:

_____

☐ YES ☐ NO Do you smoke or have you ever smoked? If so, how much per day? _____

☐ YES ☐ NO Have you ever worn or trialed a hearing aid(s) before? If so, describe your experience(s): _____

_____

Are you currently taking prescription medication(s), and do you have any allergies to medication(s) or non-drug related items? If so, please list them here, or you may **provide us a medication list**:

_____

_____

Have you ever had or currently have any of the below medical conditions? If yes to any of the following, describe if needed:

☐ YES ☐ NO Arthritis: _____

☐ YES ☐ NO Cancer (any chemotherapy or radiation): _____

☐ YES ☐ NO Diabetes and/or Thyroid-Related Issues: _____

☐ YES ☐ NO Emphysema/COPD and/or Sleep Apnea: _____

☐ YES ☐ NO Heart Attack/Hypertension: _____

☐ YES ☐ NO Parkinson's/Tremors: _____

☐ YES ☐ NO Stroke/TIA: _____

☐ YES ☐ NO Other(s): _____

Is there anything else you would like the Audiologist to know? If yes, please describe: _____

_____

PATIENT PRIVACY POLICY

Patient's Name: _____ Date of Birth: _____

I hereby authorize Hanover Audiology, PLLC to use and/or disclose my health information which specifically identifies me, or which can reasonably be used to identify me to carry out my treatment, payment, and healthcare operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Hanover Audiology, PLLC can refuse to provide services to me. I have been informed that Hanover Audiology has prepared a Privacy Notice that more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment payment, and healthcare operations.

I understand that I have the right to review such Notice prior to signing this consent. I understand that I may revoke this consent at any time by notifying Hanover Audiology, PLLC, in writing, but if I revoke my consent, such revocation will not affect any actions that Hanover Audiology, PLLC took before receiving my revocation.

I authorize Hanover Audiology, PLLC to share medical/billing information about my care/account to the following (for example: a spouse or other family member, a primary care physician, ENT, etc.)

Names: _____

_____

The above policies will be in effect so long as you are a patient of Hanover Audiology, PLLC, or if you are otherwise notified. Please sign if you have reviewed and accept the above privacy statements.

Authorized Signature: _____ Date: _____

BILLING POLICIES

Please note that many insurance companies (including Medicare) require a medical referral. If I do not know if I need a medical referral, I am responsible for contacting insurance company prior to my visit. I understand that if I do not have a referral, no services will be rendered until the referral is received or until I sign a waiver acknowledging acceptance of financial responsibility. Payment in full will be required on the day of my appointment.

I have listed all health insurance plans from which I may receive benefits. I hereby authorize payment of medical benefits billed to my insurance to Hanover Audiology, PLLC. I hereby accept responsibility for payment for any service(s) or products provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance if Hanover Audiology does not participate with my insurance or if I otherwise agree in writing. I agree to pay all co-payments, coinsurance, and deductibles at the time services are rendered.

Hanover Audiology will submit your claims and assist you in any way we reasonably can to help get your claims paid. I understand that my insurance company may need me to supply certain information directly. It is my responsibility to comply with their request. The balance of my claim is my responsibility whether your insurance company pays my claim. My insurance benefit is a contract between myself and my insurance company, Hanover Audiology, PLLC are not party to that contract.

If Hanover Audiology, PLLC submits to my insurance for services and/or products, insurance pays the claim, and monies are owed to me, I understand that Hanover Audiology will provide me reimbursement issued within 30 days of receiving payment from the insurance company.

The above policy will be in effect so long as you are a patient and receive services from Hanover Audiology, or if you are otherwise notified. Please sign if you have reviewed and accept the above billing statements:

Authorized Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____