HSDC
Hearing, Speech & Deaf Center

Artz Communication Center
1625 19th Ave Seattle, WA 98122
206.323.5770 www.hsdc.org

Audiology Adult History Form

Title: Mr./Ms./Dr./Other_____ Client's Name: _____ Date: _____

Date of Birth: _____ Person completing this form/Relationship: _____

I. Hearing History

1. What specific questions would you like to have answered: _____
   _____
   _____
2. How long have you had trouble hearing? _____
3. Has your hearing become worse in the last year? ☐ Yes ☐ No
4. Which is your better ear? ☐ Right ☐ Left ☐ Same ☐ Unsure
5. Is your hearing better some days than others? ☐ Yes ☐ No
6. Do you have trouble understanding: (*please check*)
   ☐ At home ☐ At work ☐ In noise
   ☐ With one person ☐ In small groups ☐ In crowds
   ☐ On the phone ☐ With radio/TV ☐ At the movies
   ☐ Other: _____
7. Have others brought attention to your hearing loss? ☐ Yes ☐ No
8. Do you feel your hearing has affected your relationships with family, friends, or co-workers?
   ☐ Yes ☐ No

II. Medical History:

1. Have you had your hearing tested before? ☐ Yes ☐ No
   If yes, when? _____ Where? _____
   What were the results? _____
2. Have you had your ears examined by a physician? ☐ Yes ☐ No
   If yes, when? _____ Where? _____
   What were the results? _____
3. Do you know what caused your hearing loss? ☐ Yes ☐ No
   If yes, please explain: _____
   _____
4. Do you suffer from *(please check)*
   ☐ Tinnitus (Ringing) ☐ Dizziness ☐ Ear Pressure ☐ Nausea
   ☐ Ear pain ☐ Ear infections ☐ Ear drainage ☐ Allergies
   ☐ Frequent colds ☐ Other: _____
5. Does anyone in your biological family have a hearing loss? ☐ Yes ☐ No
   Please list: _____

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II. Medical History (*continued*)

6. Have you been treated for any medical problem with your ears? ☐ Yes ☐ No
   Have you had ear surgery? ☐ Yes ☐ No
   If yes, please explain: _____
   _____
7. Have you ever been exposed to high levels of noise? ☐ Yes ☐ No
   ☐ Occupational ☐ Recreational ☐ Other: _____
   Please describe: _____
8. Do you wear ear protection in noise? ☐ Yes ☐ No
9. Have you had any major illnesses? _____
10. Have you experienced head trauma? _____
11. Are you currently taking any medications? ☐ Yes ☐ No
    Please submit a current list of medications. This should be updated at every visit.
12. Do you currently use any tobacco products? ☐ Yes ☐ No

III. Hearing Aid History

1. Do you have hearing aids? ☐ Yes ☐ No Which ears? ☐ Right ☐ Left ☐ Both
2. Make/Model: _____ When were they purchased? _____
3. How long have you worn hearing aids? _____
4. How much do you use your present hearing aid(s)? _____
5. Are your hearing aid(s) helpful for you? ☐ Yes ☐ No
   Describe: _____
6. Describe any problems you may have with your hearing aids: _____
   _____

IV. Special Health Considerations/Precautions

HSDC Staff will review charts and pay special attention to any disclosed healthcare needs (e.g., seizures, pacemaker, diabetes, etc.) Please describe any special precautions or procedures we may need to know in case of emergency:

_____

_____

V. Emergency Contact:

Name: _____ Relationship: _____

Phone: _____ Email: _____

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Medications List

Name: _____ Date of Birth: _____

Medications current as of: _____ _____ _____

_____ _____ _____

Please list all medications and dosages that you are currently taking. This information is confidential and will be kept in your client file. Should you need to make any changes to the form, you are welcome to do so in-person or over the phone at 206.323.5770.

This list must be reviewed at each diagnostic hearing test.

MEDICATION NAME	DOSAGES

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Authorization for Use/Disclosure of Protected Health Information

Client Name: _____ **Birthdate:** _____

Release of Protected Health Information

My protected health information may be disclosed to the following:

Name: _____ **Facility**: _____

Phone: _____ Fax: _____

Address: _____

Name: _____ **Facility**: _____

Phone: _____ Fax: _____

Address: _____

Name: _____ **Facility**: _____

Phone: _____ Fax: _____

Address: _____

Name: _____ **Facility**: _____

Phone: _____ Fax: _____

Address: _____

Signature required for release/obtain/exchange for information. **I understand that by signing below:**

- I authorize HSDC to release protected health information to the parties listed above.
- I authorize HSDC to release any information required to insurance companies, medical providers, and other as required by law or court order.
- I understand that in order to revoke these rights, a written notification must be submitted to HSDC.
- Authorizing the disclosure of health information is voluntary. My treatment or eligibility will not be conditioned upon my authorization of this disclosure.

_____ _____

Signed name of patient/personal representative Date

_____

Printed name of patient/personal representative

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Financial Agreement and Attendance Policy

Financial Agreement

I authorize treatment of the person named below and agree to pay all fees for such treatment.

- I authorize my insurance benefits to be paid directly to the provider of service and I am financially responsible for non-covered services, co-pays, deductibles, and exhausted benefits.
- I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges
- I am financially responsible for a billing fee. I understand that balances over 60 days may incur a billing fee of 1% per month (12% APR), (RCW 19.52) with a minimum charge of $1.00 monthly.
- I understand that HSDC charges a $30.00 fee for returned checks (per RCW 62A.2-515 and 520). If the original charge and the resulting NSF fee are not paid within 30 days, the account will be sent to collections.
- In the event it should become necessary to place for collection an unpaid balance due for services rendered to me or my family, I/we agree to interest and collection fees, including attorneys' fees and costs.

Attendance and Cancellation Policy

All appointments must be cancelled with at least 24 hours' notice.

- A missed appointment/no show fee of $75.00 may be charged for all appointments that are not cancelled with 24 hours' notice. Except in the case of emergency or illness,
- Patients who are more than 15 minutes late to an appointment will be marked as a "no-show" and will need to reschedule.
- If a client misses more than 20% of their appointments, they may be placed on "Walk-in" only status, meaning that they will not be given a routine time for scheduled appointments.
- If ongoing attendance is poor or problematic, services may be terminated.

_____ _____

Signed name of patient/personal representative Date

_____

Printed name of patient/personal representative

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PATIENT FINANCIAL RESPONSIBILITY DISCLOSURE STATEMENT

Your signature below forms a binding agreement between Hearing, Speech & Deaf Center (HSDC) and the Patient who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

Our Medical Insurance & Private Pay Policy

Medical Insurance: We have contracts with many insurance companies, and we will bill them as a service to you. As the Responsible Party, you are responsible if your insurance company declines to pay for any reason.

- Private pay patients –Full payment amount due at the start of the appointment.
- Inform HSDC of the current address and phone number for the Patient and the Responsible Party.
- Present all current insurance cards prior to each office visit.
- Verify at each visit that the information is current by signing our data sheet.
- Pay any required copay at the start of the visit.
- When HSDC receives an explanation of benefits (EOB) from your insurance company, any charges for example: None covered service or Deductible, Co-insurance will be billed to you.
- Pay any additional amount owing within 15 days of receiving a statement from our office.

Attendance and Cancellation Policy

All appointments must be cancelled with at least 24 hours' notice.

- A missed appointment/no show fee of up to $75.00 may be charged for all appointments that are not cancelled with 24 hours' notice. Except in the case of emergency or illness,
- Patients who are more than 15 minutes late to an appointment will be marked as a "no-show" and will need to reschedule.
- If a client misses more than 20% of their appointments, they may be placed on "Walk-in" only status, meaning that they will not be given a routine time for scheduled appointments.
- If ongoing attendance is poor or problematic, services may be terminated.

Returned Check Policy

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the Patient or the patient's Responsible Party will be responsible for the original check amount in addition to a $ 25.00 Service Charge. Once notice is received of the returned check, HSDC will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance—in addition to the $25.00 check Service Charge.

Non-Payment on Account

Should collection proceedings or other legal action become necessary to collect an overdue account, the Patient or the patient's Responsible Party understands that HSDC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The Patient, or patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 50%, all court costs and attorney fees, and a collection fee added to the outstanding balance. By signing below, you agree to accept full financial responsibility as a Patient who is receiving medical services or as the Responsible Party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

_____ _____

Signed name of patient/personal representative Date

_____

Printed name of patient/personal representative