PATIENT INFORMATION:

Patient's Name: (First) ________________________ (MI) ______ (Last) ______________________________

Address: (Street)_______________________________________ (City) ________________________ (State)______ (Zip) __________

Phone Numbers: (H) _______-______-_______ (W) _______-________-______ ext. ______ (C) ________-_________-_________

Social Security #: ________-______-________ **Date of Birth: ______/______/________** Gender: ❑ Male / ❑ Female

Marital Status: ❑ Single / ❑ Married / ❑ Divorced / ❑ Separated / ❑ Widowed
Employment: ❑ Full Time / ❑ Part Time / ❑ Unemployed / ❑ Retired

****Email Address**____

How did you hear about us? ____

Primary Care Doctor:

Name: ____

Address:____

Phone: ____ **Fax:** ____

PRIMARY INSURANCE INFORMATION:

Name of Insurance Company: ____

Subscriber ID#:____ **Group #:** ___________________________

Insured's name: (First) ______________________________ (MI) ________ (Last) _________________________________

Patient's relationship to insured: _______________________ Insured's date of birth: ______/______/________

Insured's Numbers: (H) _______-_______-______ (W) _____-_____-_____ ext_____ (C) _______-_______-______

Insured's Address (If different from above):

(Street) ____ (City) _________________________ (State) _______ (Zip) _________

OTHER INSURANCE INFORMATION:

Name of Insurance Company: ____

Subscriber ID#:____ **Group #:** __________________________

Insured's name: (First) __________________________ (MI) ________ (Last) ____________________________

Patient's relationship to insured: _______________________ Insured's date of birth: _______/______/________

Insured's Numbers: (H) _______-_______-______ (W) _____-_____-_____ ext_____ (C) _______-_______-______

Insured's Address (If different from above):

(Street) __________________________________ (City) _____________________ (State) ______ (Zip) _______

I authorize any holder of medical or other information about me to release any information needed to process this or other claims I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

SIGNATURE:____ **DATE:** ______/______/_____

Use and Release of Health Information

1. I hereby authorize and direct Island Better Hearing, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such treatment. Upon my request for release of my medical records, I hereby authorize Island Better Hearing to furnish all records and results to the parties I specify.

2. As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the US Department of Health and Human Services Office for Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices, or in accordance with your wishes as stated below.

This document authorizes Island Better Hearing to send/give my medical information as noted:

Leave a voice mail recording including my Personal Health Information on my home/cell phone:
☐ Yes ☐ No

Leave a voice mail recording including my Personal Health Information on my business phone:
☐ Yes ☐ No

Use of electronic communication systems (i.e. fax, electronic messaging) to transmit prescription, treatment, disorder related information, lab or other results:
☐ Yes ☐ No

Use of email to transmit treatment or disorder related information which may include a diagnosis, lab or other results sent to me, even if the email is not encrypted (not protected over the Internet):
☐ Yes ☐ No

Speak to a family member of my choosing (Personal Representative) regarding my Personal Health Information:
☐ Yes ☐ No

Name of Personal Representative: ____

3. On this date _______________, I received and reviewed the Island Better Hearing Notice of Privacy Practices, which describes how my medical information may be used and disclosed and explains how I can get access to this information.

   I had an opportunity to raise questions regarding this policy and all of my questions have been answered.

4. Island Better Hearing may periodically send you educational and marketing materials related to Island Better Hearing, including office promotions, and new products and services being offered. If you DO NOT wish to receive this information, please check and initial here to opt out of marketing activities.

☐ I wish to opt out of all marketing activities _______ (initial)

The authorizations made above will remain effective until such time as I notify Island Better Hearing in writing of requested changes.

____
Patient Name (Print)

____
Date of Birth

____
Signature

____
Date

Island Better Hearing

NOTICE OF PRIVACY POLICY

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.

YOU KNOW AND TRUST ISLAND BETTER HEARING, WE VALUE YOUR TRUST. We understand the confidential nature of the information you provide IBH (Island Better Hearing) We want you to understand how IBH may use and disclose certain information you provide us, and what rights you have concerning that information. This privacy policy will tell you:

- What information is protected?
- How IBH may use and disclose your protected information
- Your rights concerning you protected information

WHAT INFORMATION IS PROTECTED? Information protected by this privacy policy includes information IBH receives or creates that identifies you and concerns the following:

- Your past, present or future medical health or condition.
- Medical care that is provided to you.
- The past, present or future payments for medical care or condition provided to you.

HOW WE MAY USE OR DISCLOSE PROTECTED INFORMATION. IBH may use or disclose your protected information to provide you with treatment, obtain payment for your treatment, or perform health care operations. Some examples of how we may use or disclose your protected information for these reasons are as followed.

TREATMENT. Our practice may use your individually identifiable health information (IIHI) to treat you. We may use or disclose IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as spouse, children or parents. Finally, we may also disclose your IIHI to other healthcare providers for purposes related to your treatment.

PAYMENT. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. We may also use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may also disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

HEALTH CARE OPERATIONS. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

IBH may also use or disclose your protected information for other reasons. Those reasons and some examples of how we may use or disclose your protected information for those reasons are as followed.

COMMUNICATING WITH YOU. We may use your protected information to contact you to remind you of an appointment, equipment, or information about treatment alternatives.

HEALTH OVERNIGHT AGENCIES. We may disclose your IIHI to agencies authorized by law to perform audits, investigations or inspections for the oversight of the health care system, government benefit programs, government regulatory programs or civil rights laws.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS. We may disclose your IIHI in response to a court order, administrative order, subpoena, warrant, or other lawful process.

LAW ENFORCEMENT. We may disclose your IIHI as required by law in response to requests from law enforcement services. We may hire third parties to perform certain services for us. We may disclose your IIHI to these third parties so that they can perform services we have asked them to do. These third parties will be required to protect your information and will not be allowed to use your information for any purpose other than to provide the services we have requested.

SPECIAL CIRCUMSTANCES. We may disclose your IIHI in certain special circumstances. Such circumstances include disclosures to agencies authorized by law to collect information for national security and intelligence activities, for specialized government functions in the event you are a veteran or are in the military, for investigation of a death or identification of a deceased person, for review of product quality and safety, to avert a threat to health or safety of an individual or the public, or to comply with requirements for workers compensation programs. The examples given above are for illustrations only, they may not be all-inclusive. IBH may also use or disclose your IIHI as otherwise required by law. IBH will obtain your written authorization before using or disclosing your IIHI for any reason other than those included in this notice. You may revoke your authorization in writing at any time. Upon receipt of your written revocation, we will stop using or disclosing your IIHI, except to the extent that we have already taken action in reliance on the authorization. You have certain rights concerning your IIHI and this notice. These rights are as followed.

NOTICE. You may request a copy of the notice at any time. You may request a copy of the notice at any time.

Inspections and copies. You have the right to inspect and receive a copy of the IIHI we maintain about you. You may request this in writing. We may charge you a fee for the costs of copying and mailing your IIHI.

Amendments. If you feel that the IIHI we maintain about you is incomplete or incorrect, you may request that we amend it. You may request this in writing. The request must include the reason you are requesting the amendment. In certain cases, we may deny your request for amendment. If we deny your request for amendment, you may send us a written statement disagreeing your denial.

RESTRICTIONS ON USES AND DISCLOSURES. You have the right to request additional restrictions on our use or disclosure of your IIHI. Your request must be submitted in writing to us. We are not required to agree to any restrictions you request.

ACCOUNTING OF DISCLOSURES. You have the right to receive an accounting of the disclosures we have made of your protected information. The accounting will not include disclosures made for treatment, payment or health care operations, disclosures made directly to you, your friends or family members involved in your care, or disclosures authorized by you. The right to receive an accounting of disclosures is subject to certain other expectations, restrictions, and limitations. To request an accounting of disclosures, please contact us with request in writing. The first accounting you request within a 12 month period will be provided free of charge, but you may be charged for additional accountings. We will notify you of the cost involved and you may then withdraw or modify your request.

ALTERNATIVE COMMUNICATIONS. You may request that we contact you about your protected information only in writing or at a different residence. We will accommodate reasonable requests.

EFFECTIVE DATE

THIS NOTICE IS EFFECTIVE AS OF APRIL 14, 2003.

Island Better Hearing is required by law to maintain the privacy of your protected information and to provide you with this notice. Island Better Hearing is required to comply with the terms of this notice for as long as it is in effect.

ISLAND BETTER HEARING
1-03 SCHWAB ROAD
MELVILLE, NY 11747
P: 631-271-1018/ F: 631-271-1782

RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT FORM

I, ____
(PRINT NAME)

Have received a copy of ISLAND BETTER HEARING'S :

NOTICE OF PRIVACY PRACTICES.

SIGNATURE: __________________________________ **DATE:** __________/___________/_____________
OF PATIENT

<u>HEARING NEEDS ASSESSMENT QUIZ</u>:

1. **WHAT IS YOUR HEARING AID EXPERIENCE? (PLEASE CHECK OFF ALL THAT APPLY)**

- I have a hearing device & use it regularly on the: ____ Right / ____ Left ear
- I have a hearing device, but don't use it or use it only occasionally
- I tried a hearing device but returned it for credit
- I have inquired about hearing devices at another office(s), but did not purchase at the time
- I have never used a hearing device

2. These are your choices:

______ **SOUND QUALITY & CLARITY** ______ **DURABILITY & RELIABILITY**
______ **COST** ______ **APPEARANCE**

On a scale of 1-4, Please put in order (1 being the most important, 4 being the least important) the importance to you of the above choices given.

3. What motivated you to come in today?

____

4. On a scale of 1-10, where do feel you are (psychologically, emotionally, financially, etc.) regarding doing something about your hearing loss? (**Please circle one**)

1 2 3 4 5 6 7 8 9 10

Not motivated **Very motivated**

5. Please check the box which corresponds to your ability to hear in the situations listed and check how often you are in that situation.

LISTENING SITUATION	HOW WELL DO YOU HEAR IN THIS SITUATION?			HOW OFTEN ARE YOU IN THIS SITUATION?		
	POOR	GOOD	FAIR	RARELY	OFTEN	SOMETIMES
QUIET ROOM (1 OR 2 PEOPLE)	☐	☐	☐	☐	☐	☐
RESTAURANTS	☐	☐	☐	☐	☐	☐
CAR	☐	☐	☐	☐	☐	☐
TELEVISION	☐	☐	☐	☐	☐	☐
CHURCH/MEETINGS/LECTURES	☐	☐	☐	☐	☐	☐

WORK PLACE	☐	☐	☐	☐	☐	☐
TELEPHONE	☐	☐	☐	☐	☐	☐
LARGE SOCIAL GATHERINGS	☐	☐	☐	☐	☐	☐