North Hills Hearing and Balance Center & North Hills ENT

ADULT PATIENT INFORMATION

Birth Date_____ Social Security Number_____

Name_____
First Middle Last

Mailing Address_____
Street City State Zip

Occupation_____ Employer_____

Phone Number: Home ( )_____ Work ( )_____
E-mail:_____

Can you be reached or receive messages at work?_____
During what hours?_____

Spouse's Name _____Birth Date _____

Who referred you to this office?_____
Who will be responsible for payment? _____

Primary Health Insurance: _____
Secondary Health Insurance: _____

Family Doctor: _____ Telephone: _____
Need a report to your doctor? Yes No

NOTIFICATION OF POSSIBLE MEDICARE NON-PAYMENT FOR SERVICES

Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862 (a)(1) of the Medicare law. If Medicare determines that a particular service is "not reasonable and necessary", Medicare will deny payment for that service. Medicare regulations require that, in order to collect payment, you must be informed in advance that a service may not be covered. Although this implies that such services are not medically necessary, it must be emphasized that these services are needed in order to render a professional judgment of audiological diagnosis.

Based on Medicare guidelines, in your case, Medicare might deny payment for the following reasons:

( ) Medicare does not pay for audiological testing without a physician's request
( ) Medicare does not pay for hearing aid examinations or for hearing aids
( ) Other:

By signing this statement, YOU ARE AGREEING TO PAY FOR THE SERVICE(S) listed above.

Date_____ Signature _____

_____

NORTH HILLS ENT

Medical History

PAST OR PRESENT MEDICAL PROBLEMS (*Circle any problems you have or had*):

High Blood Pressure	Diabetes	Allergies	Rheumatic Fever	HIV/AIDS
Depression	Jaundice	Angina	Hepatitis (A /B/C)	Ear Infections
Kidney Stones	Asthma	Fibromyalgia	Head Injury	Heart Attack
Bronchitis	Hearing Loss	Kidney Failure	Arthritis	Meniere's Disease
Goiter	Emphysema	Chicken Pox	Urinary Infection	Irregular Heart Rate Anemia
Blood Clots	TMJ	Tuberculosis	Other Heart Disease	Sinus Infections
Stomach Ulcers	Seizures	Pneumonia	Bleeding Disorder	Excessive bleeding
Stroke	Tonsillitis		Women: Are you pregnant? Yes / No	

Cancer(Type/when):_____

Please list all other Illnesses:

_____
_____
_____
_____

SURGICAL HISTORY (*Please circle any surgeries you have had, and when*)

Ear Tubes	Tonsillectomy	Thyroid Surgery	Knee Replacement	Hysterectomy
Gall Bladder	Prostate Surgery	Ear Drum Repair	Septum Repair	Cardiac
Bypass	Hip Replacement	Tubal Ligation	Appendectomy	Hernia
Skin Cancer	Sinus Surgery	Cataracts	Cesarean Section	
Mastoidectomy				

Please List Other Operations (*please list type*):

_____
_____
_____

Hearing Health History

- Do you suspect that you have a hearing loss? _____
  For how long? _____
  Cause? _____
  Better hearing ear? Right Left Neither

- Has your hearing ever been tested? _____ Findings: _____
  _____

- Why have you decided to have your hearing tested at this time?
  I feel my hearing is poor and may need to be aided.
  Family/friends have suggested I have my hearing checked.
  Other reason: _____
  _____

- Please list the top 3 listening situations where you would like to hear better:
  1.
  2.
  3.

- Place an "x" along the line indicating how much your hearing difficulties affect you:

  No affect _____Affects communication daily

- Place an "x" along the line indicating how motivated you are to get hearing help:

  Not motivated at all_____Very motivated

- How do you feel about your hearing loss (embarrassed, frustrated, etc.) _____
  _____

- Please put in rank order from 1-4 your most important considerations regarding hearing devices. (1 being the most important, 4 being the least important.) Please use each number only once.
  ___ Size and the ability of others not to see the hearing devices
  ___ Improved ability to hear and understand speech
  ___ Improved ability to hear and understand speech in noisy situations
  ___ Cost of the hearing devices

- Do you have a history of ear infections or surgery? _____

  Details: _____
  _____

- Do you have a family history of hearing loss? _____

- Do you have ringing/noises in your ears? _____

Describe the ringing and how often it occurs: _____
_____

- Describe any significant noise exposure: _____
  _____

- Did/do you wear hearing aids? _____
  Which ear? Right Left Both Brand & Model: _____
  _____

  How long have you worn aids? _____ What styles have your worn? _____
  _____
  When/where did you purchase them? _____
  How many hours a day do you wear them? _____
  Any problems with your aids? _____
  _____

Patient's Signature _____ Date _____

HIPAA

Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be filled out on each patient annually.

DATE: _____

I authorize Geoffrey Scot, M.D. P.A. to release my medical information necessary to process my medical claim and coordinate or manage my healthcare.

In the event a family member or caregiver attends my office visit and is in the exam room at the time of my evaluation or treatment, I give Geoffrey Scott, M.D. P.A. or its employees my permission to discuss freely my condition, treatment, or diagnosis with that person.

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

May we leave a message at one of the numbers listed above about appointments, test results, and prescriptions?

YES/NO HOME/WORK/CELL ALL OF THE ABOVE

With whom may we discuss or release information about care, treatment, or diagnosis?

Name: _____ Relationship: _____ Phone#:_____

Name: _____ Relationship: _____ Phone#:_____

Signature: _____
(Signature is valid one year from date shown above)

Printed Name: _____

NORTH HILLS ENT

North Hills Hearing and Balance Center
a Division of North Hills ENT
Financial Policy

Assignment of Insurance Benefits
Patients with insurance please read and sign below.

Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of 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 you have available.

I hereby assign all medical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to North Hills Hearing and Balance Center, a division of North Hills ENT. A photocopy of my insurance card (assignment) and a copy of my driver's license are to be considered as valid as an original.

I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize North Hills Hearing and Balance Center/North Hills ENT to release all information necessary to secure the payment. If insurance pays only a portion of the bill or fails to make payment to North Hills Hearing and Balance Center/North Hills ENT within 90 days, I will be responsible for payment of balance in full at that time.

Patient's Name: _____

Patient's Signature: _____ Date _____

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