Kos/Danchak
AUDIOLOGY & HEARING AIDS

ADULT PATIENT INFORMATION

Birth Date: _____ Gender: _____ 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: _____ S.S. #: _____

Spouse's Occupation: _____ Employer: _____

Spouse's Business Phone Number: ( )_____ When can he (she) be reached? _____

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

MEDICAL HISTORY

Place a check next to any of the following that you have had or currently have:

☐ Diabetes	☐ Heart Disease	☐ Stroke
☐ High Blood Pressure	☐ Arthritis	☐ Kidney Disease
☐ Cancer	☐ Mumps	☐ Measles
☐ Meningitis	☐ Head Trauma	☐ Sleep Issues
☐ Neurologic Impairment/Headaches	☐ Anxiety/Depression	☐ Change in Appetite
☐ Lack of Energy	☐ Suicidal Thoughts or Attempts	☐ IV Antibiotics
☐ Alcohol Use	☐ Tobacco Use	☐ Other: _____

Please list any medications that you take, including prescription, over-the-counter, herbals, vitamin/mineral/dietary supplements taken routinely or on an as-needed basis.

Name: Dosage: Frequency taken: Route of administration (ex. oral):

_____

_____

_____

_____

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.
- ☐ My tinnitus is really bothering me.
- ☐ My sensitivity to sound is really bothering me.
- ☐ Other reason: _____

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ACKNOWLEDGMENT REGARDING PROTECTED HEALTH INFORMATION (PHI)

Patient Name _____ Date of Birth _____

I have received a copy of the Notice of Privacy Practices provided by Kos/Danchak Audiology. I understand how the clinic will utilize my protected health information (PHI) and my rights regarding my protected health information.

Signature of Patient or Parent/Legal Guardian _____ Date _____

****Releasing Information to Me, My Family and Caregivers**

**This is not for physicians or doctors.

I authorize this center to release my PHI (including the evaluation report) to the following people involved in my care (please include yourself, spouse, parents, children, etc., as desired).

Name	**Relationship**	**Phone**
_____	(Myself)	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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HEARING HEALTH HISTORY

Do you have a history of the following? Check all that apply:

☐ Ear Infections/Ear Surgery — Details: _____
☐ Noise Exposure — Type: _____
☐ Family History of Hearing Loss — Who: _____
☐ Family History of Tinnitus — Who: _____
☐ Family History of Sound Tolerance Issues — Who: _____

Do you experience dizziness? ☐ Yes ☐ No
Constant: _____ Episodic: _____ How frequent? _____
Dizziness triggers: _____
Does anything provide relief: _____
Associated changes in hearing or ringing/pressure in the ears: _____

Do you have ringing/noises in your ears (tinnitus)? ☐ Yes ☐ No Describe: _____
Constant: _____ Episodic: _____ When were you first aware of it: _____
Does anything seem to make your tinnitus change? _____
Have you seen other specialists about your tinnitus? ☐ Yes ☐ No
How many? _____ What were you told? _____
What tests were done, when and findings? _____

Are you extra sensitive to external sounds? ☐ Yes ☐ No
When did it start? _____ List the uncomfortable sound: _____
Treatments you have tried: _____
Have you seen other specialists about your sound sensitivity? ☐ Yes ☐ No
How many? _____ What were you told? _____

Do you suspect that you have a hearing loss? ☐ Right ☐ Left ☐ Both Poorer ear: _____
Cause: _____ Duration: _____
Does your hearing seem to fluctuate? ☐ Yes ☐ No Describe: _____
Has your hearing ever been tested? ☐ Yes ☐ No Findings: _____

Did/do you wear hearing aids? ☐ Yes ☐ No
Which ear? ☐ Right ☐ Left ☐ Both Brand & Model: _____
How long have you worn aids? _____ What styles have you worn? _____
When/where did you purchase them? _____ Hours/Day use: _____

Any problems with your aids?
Please list the top three 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 effect ◄——————————————————————► 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 list your most important considerations regarding hearing devices in rank order from one to four.
(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

Patient's Signature: _____ Date: _____

Arlington Office - 905 W. Mitchell St., Arlington, TX 76013 - (817) 277-7039
Fort Worth Office - 904 Pennsylvania Ave., Fort Worth, TX 76104 - (817) 332-8817
kdaud.com

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AUDIOLOGY & HEARING AIDS

NEW PATIENT SOURCE

Name: _____ Date: _____

Primary Care Physician: _____

How did you hear about us? Please place an "X" on the appropriate line and fill out the information associated with that answer.

☐ Friend/Patient? List name: _____

☐ Existing Patient? List name: _____

☐ Magazine? Name of magazine: _____

☐ Physician Referral? List name: _____

☐ Internet? List website: _____

☐ Other? List source: _____

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In general, the HIPAA privacy rule gives individuals the right to request confidential communications or that communications be made by alternative means, such as sending correspondence to the individual's place of business instead of the individual's home.

Patient Name: _____ Date of Birth: _____

Confidential Communications

I wish to be contacted in the following manner (check all that apply):

☐ Home ☐ Work ☐ Cell, which is: _____

OK to leave a message with detailed information: ☐ Yes or ☐ No

Leave a message with your name and a callback # only: ☐ Yes or ☐ No

Written Communication

OK to mail to my home/work/other, which is: _____

_____

Email, which is: _____

_____

RECEIPT of NOTICE of PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

I, _____, have received a copy of KOS/DANCHAK AUDIOLOGY AND HEARING AIDS NOTICE of PRIVACY PRACTICES.

_____ _____

Signature of Patient or Personal Representative Date

**The Notice of Privacy Practices is available at www.northtxhearing.com as well as in the office upon request.*

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AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES

Patient Name: _____ Date of Birth: _____

By signing this form, I am authorizing Kos/Danchak Audiology & Hearing Aids to send me marketing communications for which they may receive financial remuneration from a third party whose products or services are being marketed, such as:

A. Educational and marketing information on products and services offered by Kos/Danchak Audiology & Hearing Aids
B. Communications concerning treatment alternatives or other health-related products or services

**I understand that I have the right to "opt-out" of receiving such communications.*

Other communications for such purposes that do not involve financial remuneration are adequately captured in this practice's Notice of Privacy Practices (NPP).

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the contact office listed below. I understand that revocation of this authorization will not affect any action the above-named entity took in reliance on this authorization before the above-named entity received my written notice of revocation.

Contact Office: Kos/Danchak Audiology & Hearing Aids **Phone:** (817) 277-7039 **Fax:** (817) 801-3231
Email: info@kdaud.com **Address:** 905 W Mitchell St., Arlington, TX 76013

I understand that this authorization is voluntary and that Kos/Danchak Audiology & Hearing Aids cannot condition my treatment, services, etc., on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18 unless there is proof of legal guardianship.

Patient or Personal Representative Signature: _____ Date: _____

Employee Who Reviewed Intake of Form: _____ Date: _____

_____ _____
Signature of Patient or Legal Guardian Date

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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 Kos/Danchak Audiology and Hearing Aids. 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 above insurance. I hereby authorize Kos/Danchak Audiology and Hearing Aids to release all information necessary to secure the payment. If insurance pays only a portion of the bill or fails to make payment to Kos/Danchak Audiology and Hearing Aids within 90 days, I will be responsible for payment of balance in full at that time.

Patient's Name _____ Signature _____ Date _____

MEDICARE PATIENTS:

Patients with Medicare, please read and sign below:

I request payment of authorized Medicare benefits to be made to Kos/Danchak Audiology and Hearing Aids for any services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents 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. In Medicare-assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible for only the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determined by the Medicare carrier.

Patient's Name _____ Signature _____ Date _____

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