sonus hearing care professionals   serendipity HEARING INC.

Welcome to Sonus Hearing Care Professionals

Congratulations on taking the initial steps toward better hearing health. We are delighted to welcome you to our practice and are pleased that you chose **Sonus Hearing Care Professionals** to serve your hearing needs.

Your Hearing Aid Consultation will take approximately one hour. At this appointment we will test your hearing, review the results of your audiogram, and discuss the best solution for your hearing needs.

For your convenience, we have attached your intake forms. Please print and complete the forms prior to your appointment. We encourage this for all our new patients so we may provide you with the best possible care. Please arrive 15 minutes prior to your scheduled appointment, if you intend on completing your intake paperwork in our office.

Your appointment is scheduled with:

Date: ____________________________ **Time:** ________

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Patient Demographic Form

Patient Information

(Circle One) **Mr./Mrs./Ms./Miss/Dr.:** ____
First Middle Last

Gender: Male Female **Date of Birth:** ____________________ **Social Security #:** ____________________
(optional, REQUIRED for TriWest members)

Address: ______________________________ **City:** ____________________ **State:** _______ **Zip:** __________

Secondary Address: ____________________________ **City:** ____________________ **State:** _______ **Zip:** __________

Primary Phone: ____________________ Home / Cell / Work **Secondary Phone:** ____________________ Home / Cell / Work

Email Address: ______________________________ **Marital Status:** Single Married Divorced Widowed

Primary Doctor: ______________________________ **Office Phone:** ______________________________

Referring Doctor: ______________________________ **Office Phone:** ______________________________

How did you hear about Sonus?

Insurance/Physician Referral Internet Signage Mailer/Newspaper Friend/Colleague Other

Insurance Information

A copy of your card(s) is Required. Please supply ALL cards to a Sonus Representative.

Primary Insurance: ______________________________ **Secondary Insurance:** ______________________________

Work Comp Company: ____________________________ **Claim #:** ____________________ **Date of Injury:** ___________

Adjuster's Name: ______________________________ **Phone #:** ______________________________

Policy Holder Information (if Patient is not the Primary Subscriber)

(Circle One) **Mr./Mrs./Ms./Miss/Dr.:** ____
First Middle Last

Address: ______________________________ **City:** ____________________ **State:** ______ **Zip:** __________

Primary Phone: ____________________ Home / Cell / Work **Secondary Phone:** ____________________ Home / Cell / Work

Gender: Male Female **Date of Birth:** ____________________ **Social Security #:** ____________________
(optional, REQUIRED for TriWest members)

Employer's Name: ______________________________ **Office Phone:** ______________________________

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Patient Demographic Form

Release of Information

I hereby authorize Sonus to release any medical information about the patient necessary to determine liability for payment and to process any claim for examination, treatment or devices received by the patient. I also authorize Sonus to release the medical records of the patient to the patient's referring physician or family physician indicated on the first page of this form.

Financial Agreement

Payment for services rendered is due at the time of service. Upon request, Sonus will file your insurance claims for all services rendered. The patient or guardian, if patient is a minor, is ultimately responsible for the payment for devices, treatment, and care. Sonus will bill your insurance based on the most updated and correct insurance information supplied by the patient or responsible party. Patients or guardians are responsible for payment of all co-payments, co-insurances, and deductible amounts associated with the benefits billed to their insurance plan, including services deemed "non-covered services". Co-payments, co-insurances, deductibles, and cost of non-covered services, are due at the time services are rendered. If payment is not collected at the time services are rendered, payment is due within 30 days from receipt of bill.
Patient may incur additional charges where applicable, and is responsible for payment of these charges. Charges may include:

-Returned Check Fee: $25.00

-Missed Appointment/Late Cancellation Fee: $25.00

-Office Visit Fee: $30.00 (per visit, after warranty expiration)

Please initial each line and sign and date the bottom of this form, acknowledging you have read and understand each statement and this form in its entirety.

_________ I have been advised that the benefits quoted are an **estimate**, based on plan details supplied by my insurance carrier to Sonus.

_________ I understand that I am financially responsible for any balance not paid by my insurance carrier.

_________ I authorize Sonus Hearing Care Professionals and associated entities to bill my insurance carrier for services Sonus is rendering or has rendered.

Assignment of Insurance Benefits

I authorize direct payment to Sonus of any insurance or health benefits otherwise payable to the patient for treatment or devices. I understand any figures presented to me are estimates and they are not a guarantee of payment. Insurance coverage and payment is based on the contract between the insurance carrier and the patient, and Sonus and the patient's insurance carrier. I am financially responsible for any balance related to good or services rendered by Sonus that have been billed to my insurance carrier on my behalf. I agree to accept financial responsibility for any charges not paid by my insurance. I am aware that Medicare does not pay for hearing devices or fitting examinations.

Financial Responsibility Agreement for those other than Client's Legal Representative

I agree to accept financial responsibility for the goods and services rendered to the patient and accept the terms of the Release of Information, Financial Agreement, and Assignment of Insurance Benefits provisions above.

I have read and agree to the terms outlined above.

____ Signature of Patient or Legal Representative

______________ Date

______________________ Relationship to Patient

______________________ Sonus Witness Signature

______________ Date

Adult Case History Form

Patient Name: ________________________________ **Age:** _______ **Date:** __________________

1. **Chief complaint(s):**
   Decreased Hearing or Understanding: Right Left Both
   Fullness/Pressure in Ear: Right Left Both
   Dizziness/Vertigo
   Tinnitus/Ringing/Buzzing: Right Left Both Constant Intermittent
   Sudden Change in Hearing: Right Left Both
   Pain/Discomfort in Ear: Right Left Both
   Drainage/Discharge from Ear: Right Left Both

2. **How long have you noticed this difficulty?**: ______ Years Months Days Sudden Gradual

3. **Is one ear better than the other?:** Right Left Neither

4. **Is this problem due to a work-related injury/exposure?** Yes No
   If **yes,** please explain and give date of injury:

____

____

5. **Have you ever been exposed to loud noise?** Yes No
   If **yes,** please check all that apply:
   ☐ Farm/ Factory Machinery ☐ Power Tools ☐ Firearms ☐ Music
   ☐ Jet Engine ☐ Military ☐Other: ___________________________

6. **Do your ears produce a buildup of wax?**: Yes No

7. **Have you seen a physician about your ears or your hearing?:** Yes No
   If **yes,** when and where?: ____

8. **Have you ever had a *hearing test* before?:** Yes No
   If **yes,** how long ago and what were the results?: _______________________________________

9. **Have you had *surgery, chemotherapy, or radiation* that affected your hearing or balance?**
   Yes No
   If **yes,** what type and when?: ____

____

10. **Is there a history of hearing loss in your family?:** Yes No
    If **yes,** whom?: ____

11. **Do you wear a pacemaker?:** Yes No

12. **Do you wear hearing aids?:** Yes No Right Left Both
    If **yes,** how long? __________ years How would you rate them on a scale of 1-10? ___________

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Adult Case History Form

Please check (X) if you have experienced any of the following:

- ☐ Tubes in eardrum
- ☐ Ear Surgery
- ☐ Fluid behind the eardrum
- ☐ Popping sensation in the ear
- ☐ Ear drainage/bleeding
- ☐ Dizziness/Vertigo
- ☐ Fluctuating/sudden hearing loss
- ☐ Ear infections within last year
- ☐ Swimmer's Ear
- ☐ Sensitivity to loud sounds
- ☐ Abnormal ear structure
- ☐ Wax Removal

Describe: ____

____

____

Please check (X) if you have been diagnosed with any of the following:

- ☐ Otosclerosis
- ☐ Cholesteatoma
- ☐ Bell's palsy
- ☐ Labyrinthitis
- ☐ Meniere's disease
- ☐ Barotrauma
- ☐ Permanent hearing loss
- ☐ Ossicular dislocation/fixation
- ☐ Acoustic neuroma

Describe: ____

____

____

Please check (X) if you have experienced any of the following:

- ☐ Heart disease
- ☐ Stroke/TIA
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Hypothyroidism
- ☐ Asthma
- ☐ Mental illness
- ☐ Hepatitis A, B or C
- ☐ Liver Problems
- ☐ Mumps
- ☐ Meningitis
- ☐ Measles
- ☐ Scarlet fever
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Head trauma
- ☐ Loss of Consciousness
- ☐ Exposure to chemicals/solvents
- ☐ Kidney or renal problems
- ☐ Chronic sinus infections
- ☐ Environmental allergies
- ☐ Cancer
- ☐ Radiation/chemotherapy
- ☐ Long term IV antibiotics
- ☐ Depression or anxiety
- ☐ Migraines

Please indicate if you currently take medications for any of the following:

- ☐ Blood pressure
- ☐ Diuretics (fluid pills)
- ☐ Aspirin
- ☐ Blood thinners
- ☐ Cholesterol

Please list your current prescriptions/reason for taking: ________________________________

____

____

____

____

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Consent and Acknowledgment Form

Patient's Name: ___________________________________ **Date of Birth:** ____________________

Consent for Release of Information

1. Release of Information. I authorize Sonus to disclose and furnish copies of any information relating to my care at a Sonus Hearing Care Professionals to:
   - any person or health care provider Sonus believes to be involved in my care;
   - any third party payor or other party that may provide health-related benefits to me or may be financially responsible for the services I receive;
   - any other person or organization I may specify in writing; and
   - as allowed by applicable state and federal law, any other persons or organizations as necessary for my treatment, payment or Sonus health care operations

In certain cases, such as when I request to have my records sent to another provider, I understand that Sonus may charge me, and I agree to pay, a copying fee for Sonus costs in photocopying or otherwise reproducing the records.

2. Effective Date; Revocation. I understand that I may revoke this consent at any time by giving written notification to Sonus. This consent expires on the earlier of: (i) the date Sonus receives a written notice of revocation; or (ii) the date that the consent expires in accordance with governing law. I understand that my revocation will be ineffective to the extent Sonus has relied upon the permission granted in this consent.
3. Additional Rights. I understand that a more detailed description of my rights regarding my records can be found in Sonus Notice of Privacy Practices.

Acknowledgment of Receipt of Notice

Acknowledgment. By signing below, you are acknowledging that you have received a copy of our Notice of Privacy Practices.

Signature of customer (or representative): ____

Date: ____

Print Name of Customer: ____

If you are a representative, Print your name: ____

Describe your authority: ____

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Hearing Inventory "HI" for Patient

Patient ______________________________ Date ________________ HI Score _____________________

At Sonus, it is our mission to find the best personal solution for each individual's communication needs. We will only be successful in reaching this goal if we take the time to compile the following information about you.

Please answer the following questions by checking the appropriate response.

	Yes	Sometimes	No
1. Does a hearing problem cause you to feel embarrassed when you meet new people?	☐	☐	☐
2. Does a hearing problem cause you to feel frustrated when talking to members of your family?	☐	☐	☐
3. Do you have difficulty hearing when someone speaks in a whisper?	☐	☐	☐
4. Do you feel burdened by a hearing problem?	☐	☐	☐
5. Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?	☐	☐	☐
6. Does a hearing problem cause you to attend large group situations less often than they would like?	☐	☐	☐
7. Does a hearing problem cause you to have arguments with family members?	☐	☐	☐
8. Does a hearing problem cause you difficulty when listening to TV or radio?	☐	☐	☐
9. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	☐	☐	☐
10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	☐	☐	☐

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Hearing Inventory "HI" for Companion

Name ______________________________ Date ________________ HI Score _____________________

Patient ___________________________ Relationship to Patient _______________________________

At Sonus®, it is our mission to find the best personal solution for each individual's communication needs. We will only be successful in reaching this goal if we take the time to compile the following information from those closest to the patient…you!

Please answer the following questions by checking the appropriate response.

	Yes	Sometimes	No
1. Have you observed a situation where a hearing problem caused him/her to feel embarrassed when meeting new people?	☐	☐	☐
2. Do you feel a hearing problem causes him/her to feel frustrated when talking to members of his/her family?	☐	☐	☐
3. Have you noticed that he/she has difficulty hearing when someone speaks in a whisper?	☐	☐	☐
4. Do you believe he/she is burdened by a hearing problem?	☐	☐	☐
5. Are you concerned that a hearing problem causes him/her difficulty when visiting friends, relatives or neighbors?	☐	☐	☐
6. Do you think that a hearing problem causes him/her to attend large group situations less often than they would like?	☐	☐	☐
7. Have you ever felt that a hearing problem causes him/her to have arguments with family members?	☐	☐	☐
8. Have you noticed that a hearing problem causes him/her difficulty when listening to TV or radio?	☐	☐	☐
9. Are you concerned that any difficulty with his/her hearing limits or hampers their personal or social life?	☐	☐	☐
10. Have you observed that a hearing problem causes him/her difficulty when in a restaurant with relatives or friends?	☐	☐	☐

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