COATES
HEARING CLINIC, P.A.

Patient Information

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Gender: _____ Email: _____

Mobile Cell Phone: _____ (Permission to leave voicemail? Circle: YES or NO)

Home Phone: _____ (Permission to leave voicemail? Circle: YES or NO)

Marital Status: _____ Name: _____

Emergency Contact Name: _____

Relation: _____ Emergency Contact Number: _____

Primary Care Physician (PCP) Name: _____

PCP Practice Name: _____Phone: _____

Primary Insurance Company: _____

Policy Holder: _____ Relationship: _____ DOB: _____

Secondary Insurance Company: _____

Policy Holder: _____ Relationship: _____ DOB: _____

I authorize Coates Hearing Clinic, P.A., to release information requested with regard to processing my health insurance claims (if applicable). I have read all the information on this sheet and certify that this information is correct to the best of my knowledge. I will notify Coates Hearing Clinic, P.A., of any changes in my health status or in the above information.

Patient Signature_____ **Date**_____

Guardian Signature if Minor_____ **Date**_____

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Case History Questionnaire

Patient Name: _____ **Date of Birth:** _____

What is the main reason for coming to see us today?

_____

Circle YES or NO below:

Do you feel like you have hearing loss? YES or NO

Has your hearing loss been gradually getting worse over the years? YES or NO or UNKNOWN

Have you ever experienced sudden hearing loss? YES or NO

Do you have family history of hearing loss? YES or NO or UNKNOWN

Have you been around loud noise in the past? YES or NO

Do you wear hearing aids? YES or NO

Do you know someone who wears hearing aids? YES or NO

Do you have trouble hearing on the phone? YES or NO

Are there certain situations where you have trouble hearing or understanding conversation?

_____

Are there certain people who you struggle to hear or understand?

_____

With the research link of hearing loss and other health conditions, it is important for Dr. Coates to fully evaluate the cause of your issues. **Check the box** below of any medical history that applies to you:

- ☐ Diabetes
- ☐ Migraines or headaches
- ☐ Cardiovascular, heart disease
- ☐ Jaw clenching, grinding or popping
- ☐ High blood pressure or high cholesterol
- ☐ Dementia, cognitive decline or Alzheimer's disease
- ☐ Dizziness, vertigo, light-headedness or off-balance symptoms
- ☐ Tinnitus (ringing, buzzing, whooshing, crickets or other sounds in the ear/s or head
  - ☐ Right ear ☐ Left ear ☐ Both ears ☐ Difficult to tell
- ☐ Ear pain or recent infection
- ☐ Ear pressure or fullness
- ☐ History of cancer treatment
- ☐ Kidney disease
- ☐ Thyroid disorder

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Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

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Assignment of Benefits

Thank you for choosing Coates Hearing Clinic, P.A., to be your healthcare provider. To serve you best, we ask that you read and sign this form to: (1) allow us to submit a claim along with your medical information to your managed care plan, insurance company, or other Program you have identified as potentially providing coverage for hearing aids and service you receive (any of which will be referred to as the "Plan") ; (2) to assign your benefits under the Plan for payment directly to us; (3) to acknowledge that you understand and agree to pay us for any applicable co-payments, deductibles and co-insurance under your Plan; and, (4) if the plan allows, to acknowledge that you understand and agree to pay for the difference between the price of the hearing aid(s) and/or services and the amount of the benefit collected from your Plan.

1. **Assignment of Benefits**
   - **a.** I confirm that the information I have provided about my Plan (or other medical benefits) is accurate, complete and correct.
   - **b.** I request that any payment, paid by the Plan be made on my behalf to Coates Hearing Clinic, P.A.
   - **c.** I authorize Coates Hearing Clinic, P.A., (or its agent) to file an appeal on my behalf for any denial of payment or adverse benefit determination made by the Plan.
   - **d.** If the Plan will not direct such payment to Coates Hearing Clinic, P.A., I agree to forward all payments which I receive, on account of covered hearing aids or services provided, that I have not yet paid for.
   - **e.** I authorize Coates Hearing Clinic, P.A., to release all medical or other information about me to the Plan necessary to determine and pay any benefits under the Plan.
2. **Financial Responsibility**
   - **a.** I understand and agree that I am responsible to pay Coates Hearing Clinic, P.A., for any co-payment on the day of my first office visit (or on the first day I receive services covered by the plan.)
   - **b.** I understand and agree that, if allowed under the Plan, I am responsible to pay for any difference between the price of the hearing aids and services which I purchase, and the amount of the benefit paid by the plan. Where the Plan covered the hearing aids or service and prohibits this practice, I will only be charged cost-sharing amount in accordance with my Plan's benefit terns.
   - **c.** I understand and agree that if any payments made by the Plan to Coates Hearing Clinic, P.A., exceed the expected payment amount so that is an overpayment, I will be notified and offered a refund, not to exceed the amount I have paid.
   - **d.** I understand and agree that if I decide to purchase hearing aids and services that are not covered under my Plan, I am responsible to pay the full price of the hearing aids and services.
   - **e.** I understand and agree that the provisions in this document apply and extend subsequent visits and appointments.

Patient/person legally responsible	Relationship to Patient	Date

COATES
HEARING CLINIC, P.A.

Consent to Exchange Information

Patient's Name: _____ **Date of Birth**: _____

I hereby give my consent for Coates Hearing Clinic, P.A., to exchange information with my referring or primary care physician (if applicable) as well as:

(Name and Address of Agency/Individual; for example: Family Member, Spouse or Guardian)

_____

_____

_____

All of the information I hereby authorize to be exchanged with the above will be held strictly confidential and cannot be released without my written consent. I understand that I have the right to inspect and copy the information to be disclosed. I understand that I may withdraw this authorization at any time.

Patient Communication: 

By signing below, you also authorize Coates Hearing Clinic, P.A., to periodically send you, via email or U.S. mail, appointment confirmations/reminders, helpful information or research related to your treatment plan, special events the clinic may have to offer, and new technology or treatment advancements.

_____ _____

Signature of Consenting Party **Date**

_____

Relationship to Patient
(must be parent / legal guardian)