VAN DOORNE
hearing care

Today's date:_____

Patient's full name_____

Address:_____

City/State:_____Zip:_____

Home Phone:_____Work phone:_____Cell Phone_____

Alternate phone for scheduling (if any)_____

May we contact you via e-mail for special events, offers or the e-newsletter? YES ____ NO____

Email address:_____

Birthdate:_____Years young_____ Male Female

Employer:_____

Name of Insurance company:_____

Secondary insurance (if applicable):_____

Family Physician_____

Spouse or Caregivers name:_____

In case of emergency: appointment changes, etc, please list an alternate number if possible_____

Name:_____Relationship_____Phone number_____

How did you hear about us?

Physician_____ Newsletter_____

Friend or Family_____ Previous Patient_____

Newspaper_____ Sign_____

Yellow pages_____ Word of Mouth_____

Website/Internet_____ Other_____

1. Other uses and disclosures of medical and billing information not covered by the privacy notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical or billing information about you, you may revoke that permission, in writing, anytime. If you revoke your permission, we will no longer use or disclose information about you. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

2. I understand that I am financially responsible for all charges whether covered by insurance or not.

_____

3. I authorize the release/disclosure of medical and or billing records from Van Doorne Hearing Care to my physician and the following people: (List others that you want us to be able to share information .)

_____ _____ _____ _____

This authorization is in effect for: _____

(length of time)

4. I authorize Van Doorne Hearing Care to contact me via email, phone at home, work or leave a message on my answering machine or voice mail. I agree to have materials sent from Van Doorne Hearing Care to my home address. I understand audiologic data may be sent to a manufacturer if amplification is necessary.

Signature of patient:

_____Date:_____

5. I authorize Van Doorne Hearing Care to bill my insurance (if applicable)

_____Date:_____

Please answer the following questions with an X by YES OR NO.

1. Do you suspect you have a hearing loss? YES__ NO__

2. Is one ear worse than the other? Which one?_____ YES__ NO__

3. Have you had any pain or discomfort in your ears in the past 90 days? YES__ NO__

4. Have you had any drainage from your ears in the past 90 days? YES__ NO__

5. Do you have tinnitus (ringing or other noises) in your ears? YES__ NO__

6. Do you have episodes of dizziness? YES__ NO__

7. Has there been any sudden change in your hearing in the past 90 days? YES__ NO__

8. Do you have hypertension? (high blood pressure)? YES__ NO__

9. Are you on any blood thinners? YES__ NO__

HHIE (Ventry and Weinstin)

PLEASE CHECK (X) THE ANSWER WHICH APPLIES TO YOU.	YES	SOMETIMES	NO
Does your hearing cause you to feel embarrassed when meeting new people?	_____	_____	_____
Does your hearing cause you to feel frustrated when talking to your fa	---------	---------	--------
Do you have difficulty hearing when someone speaks in a whisper?	_____	_____	____
Do you feel you have to struggle to hear ?	_____	_____	____
Does your hearing cause you to attend religious services less often than you would like?	_____	_____	_____
Does your hearing cause you to have arguments with family members?	_____	_____	____
Does your hearing cause you difficulty when listening to TV or radio?	_____	_____	____
Do you think your current hearing levels hampers your personal or social life?	_____	_____	____
Does your hearing cause you difficulty when in a restaurant with friends?	_____	_____	____

Please complete this form only if you currently wear hearing devices

HEARING DEVICE HISTORY

If you could improve your current hearing devices, what areas need improvement from the following:

Background noise_____

Telephone use_____

Visability_____

Wind noise_____

Feeling plugged up_____

Feedback (squealing)_____

Understanding in Quiet_____

Loud sounds too loud_____

Soft Sounds too soft_____

Require Connectivity_____

Want volume control_____

Want hearing loop_____

- Are you presently wearing hearing devices? YES_____NO_____
- Do you find yourself asking people to repeat things? YES_____NO_____
- Do you seem to think people mumble? YES_____NO_____
- Do you feel you have a problem in noisy situations? YES_____ NO_____
- Do you find yourself avoiding social events? YES_____NO_____
- Do you take your devices out to hear better? YES_____ NO_____

WHATS IMPORTANT TO YOU?

Age of your current hearing system?_____

Following you will find a list of important factors to consider when purchasing a hearing system. Please rate them in order of importance from 1 to 6, 1 is most important to you, 6 is the least important, #2 is the second most important and so on.

_____Understanding speech better

_____ Function better in noisy environments

_____Inconspicuous appearance

_____Cost

_____Comfort

_____Service

Van Doorne Hearing Care

FINANCIAL POLICY

Patient Responsibility:

Our practice is committed to providing the best treatment for our clients. Clients are responsible for all charges resulting from treatment provided by Van Doorne Hearing Care. As a service to you, we will bill most insurance carriers directly. However, primary responsibility for the account is yours. Providing correct insurance billing information is the responsibility of the client. If your insurance changes, please present your insurance card at your next visit. All clients must complete our intake registration form before being seen. Minors: The undersigned will agree to be responsible for payment of balances for services rendered to minors.

Payment Arrangements:

New and Established Clients: The portion that insurance will not pay is due at the time of visit. Insurance companies **do not guarantee payment.** If there is a balance due after insurance pays, payment is due within 30 days of the first billing. Accounts with balances over 90 days will be assessed a processing fee each month. HMO/PPO co-payments and deductibles, if required by your plan, are due at the time of each visit.
*We accept Visa, MasterCard, Discover Card, checks, cash and money orders.

Referrals:

Many insurance carriers require referrals from your Primary Care Physician before you receive care from a specialist. It is your responsibility to obtain a referral or prior authorization if your medical coverage requires either.

Insurance Billings:

Please be aware that some or perhaps all of the services you receive may be non-covered services and not considered reasonable and necessary under your insurance plan. In this instance, you will be responsible for payment.
Medicare: Van Doorne Hearing Care is a participating provider.
Workers' Compensation: In order to file a Workers' Compensation claim, you will need the name of your insurance carrier, the date of your injury and your claim number, if available. Be sure to notify the registration desk at each appointment if your visit is due to an injury covered by Workers' Compensation.

Check Returned: It is our clinic's policy to charge all patients a $25.00 fee for checks that are returned unpaid by the bank.

I have read and received a copy of this Credit Policy. I accept this policy for my appointment with Van Doorne Hearing Care.

_____
Print your name

_____ _____
Client signature or guardian if patient is a minor. (Relationship to patient if guardian) Date