Coweta Hearing Clinic
2301 Newnan Crossing Blvd., Suite 160
Newnan, GA 30265

Fayette Hearing Clinic
8 Eastbrook Bend, Suite A
Peachtree City, GA 30269

PATIENT INFORMATION

Mr. _____ Mrs. _____ Ms. _____ Miss _____ Dr. _____ Age _____
First Name _____ Last Name _____ M.I. ___
Date of Birth ___/___/___ Gender ____ Phone Number (____) _____ - _____
SS Number ____ _____ _____ Phone Number (____) _____ - _____

Street Address _____
City _____ State _____ Zip Code _____
E-Mail Address _____

Occupation / School_____
Employer / Parent's Employer_____

Spouse's / Parents Name _____

Emergency Contact Name _____ Relationship _____
Emergency Contact Phone Number (_____) _____ - _____

PHYSICIAN INFORMATION

Primary Care Physician _____
Primary Care Address/Location _____
Referring Physician _____
Referring Physician Address /Location_____

INSURANCE INFORMATION

Primary Insurance _____ ID # _____
Group # _____ Co-Pay _____
Policy Holder _____ Relationship to Patient _____

Secondary Insurance _____ ID# _____
Group # _____ Co-Pay _____
Policy Holder _____ Relationship to Patient _____

By signing below, I agree to be held responsible for all payments due, including any payments due after insurance has been filed. I also authorize Coweta Hearing Clinic to file insurance on my behalf for services rendered.

_____
Patient (Guardian) Signature Date

NAME: DATE:

Check YES, SOMETIMES, or NO for each question, **DO NOT skip** a question and **DO NOT SCORE** the test

	yes	Some-times	no	
S-1. Does a hearing problem cause you to use the phone less often than you would like?				S
E-2. Does a hearing problem cause you to feel embarrassed when meeting new people?				E
S-3. Does a hearing problem cause you to avoid groups of people?				S
E-4. Does a hearing problem make you irritable?				E
E-5. Does a hearing problem cause you to feel frustrated when talking to members of your family?				E
S-6. Does a hearing problem cause you difficulty when attending a party?				S
E-7. Does a hearing problem cause you to feel "stupid" or "dumb"?				S
E-8. Do you feel handicapped by a hearing problem?				E
S-9. Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?				S
E-10. Does a hearing problem cause you to feel nervous?				E
S-11. Does a hearing problem cause you to attend religious services less than you would like?				S
S-12. Do you have difficulty when someone speaks in a whisper?				E
S-13. Does a hearing problem cause you to visit friends, relatives, or neighbors less often than you would like?				S
E-14. Does a hearing problem cause you to have arguments with family members?				E
S-15. Does a hearing problem cause you difficulty when listening to TV or radio?				S

S-16. Does a hearing problem cause you to go shopping less often than you would like?				S
E-17. Does any problem or difficulty with your hearing upset you at all?				
E-18. Does a hearing problem cause you to want to be by yourself?				
S-19. Does a hearing problem cause you to talk to family members less often than you would like?				S
E-20. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?				
S-21. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?				S
E-22. Does a hearing problem cause you to feel depressed?				
S-23. Does a hearing problem cause you to listen to TV or the radio less often than you would like?				S
E-24. Does a hearing problem cause you to feel uncomfortable when talking to friends?				
E-25. Does a hearing problem cause you to feel left out when you are with a group of people?				S

********** STOP HERE _____

COWETA HEARING CLINIC INC.

FAYETTE HEARING CLINIC INC.

For the following 20 items, please select the choice that best describes how you have felt over the past week:	Rarely or none of the time (<1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of the time (3-4 days)	Most or all of the time (5-7 days)
1. I was bothered by things that usually don't bother me.				
2. I did not feel like eating; my appetite was poor				
3. I felt that I could not shake off the blues even with the help from my family and friends.				
4. I felt that I was not as good as other people.				
5. I had trouble keeping my mind on what I was doing.				
6. I felt depressed.				
7. I felt that everything I did was an effort				
8. I felt hopeless about the future.				
9. I thought my life had been a failure.				
10. I felt fearful.				
11. My sleep was restless.				
12. I was unhappy.				
13. I talked less than usual.				
14. I felt lonely.				
15. People were unfriendly.				
16. I did not enjoy life.				
17. I had crying spells.				
18. I felt sad.				
19. I felt that people disliked me.				
20. I could not get "going".				

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8 Eastbrook Bend • Peachtree City, GA 30269
phone 770-631-4490 • fax 770-631-4495

COWETA HEARING CLINIC INC.

FAYETTE HEARING CLINIC INC.

If your hearing test indicates that hearing aids are recommended, our Audiologists can discuss hearing aid options and recommendations for a consultation fee of $45. Please note that insurance does not cover this fee.

Patient Signature

Date

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HIPAA COMPLIANCE

HIPAA (Health Insurance Portability Act of 1996) is a regulation designed to protect confidential healthcare information through improved security standards and federal privacy legislation. It defines requirements for storing patient information before, during and after electronic transmission. It also identifies compliance guidelines for critical business tasks such as risk analysis, awareness training, audit trail, disaster recovery plans and information access control and encryption.

The HIPAA regulation has three main components that apply to "covered entities" (a covered entity is any provider of healthcare services that charges the government or insurance for their services):

1. Standard Transaction Code Sets
2. Patient Information Privacy
3. Patient Information Security (both electronic and physical records)

We are HIPAA compliant.

1. We will not disclose to anyone known or not know to you the reason you came to our office, the outcomes of testing, recommendations, nor any discussions that were made between you and our personnel without your written consent.
2. We will not provide personal information about you to any outside source. Your information including address, phone number, social security number, etc. will only be used by us to contact you or to file necessary insurance claims.
3. In addition to secured files, we use a database system that has been tested and has proven the highest levels of security which, in some cases surpass the government regulations for security.

Patient (Guardian) Signature_____ Date_____

CONSENT FOR TREATMENT, PRIVACY AND RELEASE

I consent to receive audiological services from Coweta Hearing Clinic. This consent encompasses audiological procedures including, but not limited to, diagnostic testing, rehabilitative treatment, ear wax removal, touching of ears and head and taking of ear mold impressions. I understand that this consent form will be valid and remain in effect as long as I receive audiological care from Coweta Hearing Clinic.

Patient (Guardian) Signature_____ Date_____

In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical records may be released to my physician, a designated referral physician and/or the provider, if any, who referred me here.

Patient (Guardian) Signature_____ Date_____

I hereby authorize the release of any medical or other information necessary to process my insurance claim. I further authorize payment of medical benefits to Coweta Hearing Clinic for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office. This is to serve as a long-term authorization.

May we at Coweta Hearing Clinic contact you via phone, e-mail, or regular mail to inform you of your appointments, specials, and/or reminders?

◯ yes ◯ no

Please list anyone you wish for us to be able to speak with regarding your medical records:

Name_____ Relation_____ Phone#_____

How did you hear about us? (Please check **all** that apply.)

☐ 98.1 FM	☐ Mailer	☐ Physician
☐ 720 AM	☐ Letter	☐ Friend
☐ 1470 AM	☐ Newspaper Ad	☐ Relative
☐ Buzzn Magazine	☐ National Hearing Campaign	☐ Insurance Co.
☐ Bellsouth Yellow Pages	☐ Yellow Book	☐ Internet
☐ Hometown Directory	☐ Saw Sign	☐ Chamber
☐ Rotary	☐ Restaurant	☐ Other

If Physician, Friend or Relative, please list their name.

_____

If Other, Insurance Company, Internet, or Restaurant, please explain.

_____

MEDICATION LIST

Patient Name: _____ Date: _____

Medication Name	Reason for Taking	When prescribed?
Example: Metoprolol	**Example: Irregular Heartbeat**	**Example: 2015**