GOTOHEARING.COM

Patient Intake Form

PATIENT INFORMATION

Name: Date of Birth:

Street Address:

City: State: Zip Code:

Home Phone Number: Mobile Phone Number:

Email: Occupation:

Name of Accompanying Party: Relationship:

MEDICAL HISTORY

Certain types of medication can impact hearing or may complicate taking an impression of your ear. Do you take any of the following types of medication? If so, please check the appropriate box(es) and list.

☐ Blood Thinners ☐ Heart Medications ☐ Insulin ☐ Chemotherapeutic ☐ Pain Relievers

As part of your hearing evaluation, you may come into contact with various materials. Are you allergic to any of the following? ☐ Latex ☐ Nitrile ☐ Plastics ☐ Rubber ☐ Silicone ☐ Other _____

Have you ever had medical/surgery treatment for your ears? ☐ Yes ☐ No

If yes, at what age? _____ Type of surgery/treatment: _____

Check any of the following conditions if you currently have or have had in the past.

- ☐ Arthritis
- ☐ Allergies
- ☐ Bell's Palsy
- ☐ Concussion/Skull Fracture
- ☐ Depression/Anxiety
- ☐ Cancer
- ☐ Diabetes I or II
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Fever
- ☐ HIV
- ☐ Measles/Mumps
- ☐ Meniere's
- ☐ Meningitis
- ☐ Multiple Sclerosis
- ☐ Neuropathy
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Memory Issues
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stroke/TIA
- ☐ Tuberculosis
- ☐ Vision Problem
- ☐ Other:

Type/Treatment: _____

Diagnosis: _____ _____

PRIVACY POLICY

I acknowledge receipt of the notice of Privacy Practices from our company. The notice of Privacy Practices provides information about how we may use and disclose your protected health information.

Today's Date: _____ Patient Initials: ☐

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NOTICE OF PRIVACY PRACTICES

According to HIPAA regulations, you have the right to restrict the uses or disclosures of your information made for purposes of treatment, payment, and/or healthcare operations.

- Treatment is the provision, coordination or management of hearing health care. For example, we may use and disclose your information to consult with a third party or to refer you to other health care providers. We will get your written consent prior to making disclosures outside our practice for treatment purposes, except in emergencies.
- Payment includes the activities necessary to obtain reimbursement for the provision of hearing health care. For example, we may need to give your health plan information about treatment you received at our practice so your health plan will pay us or reimburse you for the treatment. We will get your written consent prior to making disclosures for payment purposes.
- Health care operations include the activities necessary for our practice to run its business operations. For example, we may use your information to review treatment and services and to evaluate the performance of our staff.

If you have any questions regarding our privacy practices or think we may have violated your privacy rights, please contact us at one of the locations on the front of this brochure.

If your concern is not resolved, you may also submit a written complaint to the US Department of Health and Human Services. If you choose to file a complaint, we will not retaliate in any way.

This practice is determined to protect the privacy of your medical information. As we provide service to you, we create and store health information (a medical record) that identifies you. It is often necessary to share or disclose this health information in order to provide treatment for you, obtain payment, and to conduct healthcare operations in our office.

This Notice of Privacy Practices requires us to:

1. Keep your medical records private and to provide you with this notice.

2. Update our privacy practices and the terms of this notice at any time, ensuring our notice is effective, even for information recently obtained.

3. We reserve the right to make an important change in our privacy practices and change this Notice to that effect. You may contact us to request a new copy of our Notice and we will make the new Notice available upon request.

The following is a description of the different circumstances that may require our practice to use or disclose your medical information:

1. Share medical data with another provider who is responsible for your care (physicians, audiologists, nurses, any other healthcare professionals, technicians, students in healthcare, or any other people who take care of you), make referrals and/or placing lab/prescription orders.

2. Share your health insurance plan information about a treatment you received at our practice when filing a claim for reimbursement or determination of benefits.

3. Provide treatment communications concerning treatment alternatives or other health related products or services, unless we or a business associate receive financial remuneration in exchange for the communication in which case we must receive your written authorization unless the communication is made face-to-face or involves gifts of nominal value.

4. Disclose medical information to a medical examiner to identify a deceased person or to determine the cause of death, or for tissue donations.

5. Medical information may be disclosed if you are military personnel, either active or a veteran, and if required by the appropriate authorities.

6. Share medical data to the public health and/or law enforcement official whose job is to prevent or control disease, injury, or disability

7. Share medical data with a representative from the Food and Drug Administration for the purpose of reporting adverse effects stemming from defective products, etc.

8. Medical information may be disclosed when necessary, to comply with Workers' Compensation.

9. Medical information may be disclosed in response to a court and/or administrative order in a lawsuit or similar proceeding.

10. In order to contact you for fundraising activities supported by our practice. You have the option to opt out of receiving these communications by sending a written request to the privacy officer.

11. For marketing purposes for which our practice or our business associates may receive remuneration, for a disclosure that constitutes a sale of protected health information, and in all other situations not described in this policy your written authorization will be obtained before our practice will use or disclose your health information to third parties outside our practice. You have the right to revoke such authorization by providing our practice with a written request to revoke the specific authorization.

12. If a use of disclosure is required by law, the disclosure will be made in compliance with the law and will be limited to such requirements. State and federal laws may be more stringent and may prohibit certain uses and disclosures identified above. When another law is more stringent than HIPAA, we will follow the more stringent requirements.

13. To business associates to perform functions on our practice's behalf if the business associate has signed an agreement to protect the confidentiality of the information.

14. Share information about your condition(s), location and/or death to family member(s), or your personal representative(s). Prior permission by you will be obtained unless in case of emergency. If we are unable to obtain permission, we will share only the health information directly necessary for your healthcare.

You have individual rights as part of the notice of Privacy Practices. As a patient of GoToHearing you have the right to:

1. Request our practice to restrict uses and disclosures of your health information. However, we are not required to agree to the requested restriction unless you are requesting a restriction on the use and disclosure of your protected health information to a health plan for payment or healthcare operations and such information pertains to a healthcare item or service which you paid for in full and out of pocket. These requests should be made in writing to the address given in this Privacy Notice. In your request, you must tell us

(a) what information you want to limit; (b) whether you want to limit our use, disclosure, or both, and (c) to whom you want the limits to apply.

2. Be notified upon a breach of any of your unsecured protected health information.

3. Request that we communicate with you regarding your confidential medical information by different means or to different locations. This request must be made in writing to our practice.

4. Request photocopies of your medical records on file and/or a copy of this Notice of Privacy Practices. If you need a photocopy, please notify the receptionist.

5. Request a change to your health information if you think it is incomplete or inaccurate. However, if the hearing healthcare professional or office personnel believe the patient's health information is complete and accurate, he/she can refuse to make the requested changes. This request must be made in writing to GoToHearing.

6. Receive a list of all the times your medical information has been shared by our office or our business associates for six years prior to the request date, other than treatment, payment, healthcare operations and/or other specified exception.

7. Request a paper copy if you have received this Notice of Privacy Practices electronically. This request must be made in writing to GoToHearing.