Mountaineer Audiology
166 Garber Lane #2
Winchester, VA 22602
540-570-0090

Welcome to our Practice!

We look forward to meeting you and having you as a patient. We have enclosed paperwork that will need to be completed and brought with you to your appointment.

Your Appointment is ______________________________ at____________ AM/PM.

Please do not hesitate to contact our receptionist, Cheryl Seifert, if you need assistance. We require a 24 hour notice for cancellations, failure to do so will result in a $30 charge. We look forward to seeing you soon.

Best Regards,

Tara Crane, Aud, FAAA

Doctor of Audiology

Board Certified Audiologist

PLEASE NOTE

If you have Medicare Insurance, it is your responsibility to obtain an order from your primary care physician or ENT doctor prior to your appointment if hearing aids will be discussed. Per Medicare guidelines, this order is required for us to bill your insurance for services rendered. Unfortunately, if we do not have your order at time of service, you may have to be rescheduled. Fax number: 304-822-4452

If you are Truhearing, an order will not be needed but copays may apply based on your insurance plan

Mountaineer Audiology, LLC

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Medication Profile

Patient Name: ______________________________ **Age:** __________

Please list all Prescription medications:

Name of Medication	Dosage	Taken How Often?	Taken for What?	Route (Pill Or IV)

List all over-the-counter medication, vitamins and herbs that are taken on a regular basis

Name of Medication	Dosage	Taken How Often?	Taken for What?	Route (Pill or IV)

Are you allergic to any medications? Yes /No

List: ______________________________

Any history of chemotherapy or radiation treatment? Yes /No

If yes, please explain: ______________________________

____

____

Do you use tobacco products? Yes / No

If yes, what type and amount? ______________________________

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Case History

Name: ______________________________ **Date:** ____/____/______

Why did you decide to have your hearing tested? ______________________________

Where did you hear about our office?

□ Physician □ Sign □ Newspaper □ Friend □ Radio □ Other ______________________

Is there a known hearing loss? □ Yes □ No If yes, please describe: ______________________

Did your hearing loss develop gradually or suddenly? ______________________

Which do you think is your better ear? □ Right □ Left

What do you think caused your hearing loss? ______________________

Have you had surgery on your ears? □ Yes □ No If yes, what type? ______________________

Which Ear: □ Right □ Left When? ____________ Treating Physician: ______________________

Do you feel confusion or memory loss has worsened in the past 12 months? □ Yes □ No

Do your ears feel stuffy or clogged? □ Yes □ No

Do you have head noise? (i.e. ringing) □ Yes □ No

If yes, please describe: ______________________

Does anyone in your family have hearing loss? □ Yes □ No Relative: ______________________

Do you have difficulty hearing in noisy areas? □ Yes □ No

Do you have difficulty understanding conversation? □ Yes □ No

Does your family complain about the TV being too loud? □ Yes □ No

Do you own/wear a hearing aid? □ Yes □ No If so, for how long? ______________

Do you have or have you had any of the following?

□ **Ear Infections** As a child or adult? (circle one) When was the last infection? ______________

□ **High Blood Pressure** Stable or Fluctuating (circle one) When did this start? ______________

□ **Migraines** Are you light or sound sensitive during these episodes? ______ When was the last one? ______

□ **Stroke** Date of stroke ____________ Which side affected ______________

□ **Diabetes** Child or adult onset ____________ Stable or Fluctuating (circle one)

□ **Allergies** What type of allergies? ______________________

□ **Measles/Mumps** When? ______________________

□ **Head Injury** How long ago? ______________ Did you experience a concussion? __________

□ **Seizures** Date of last onset ______________

□ **Heart Disease/Surgery** – Type: ______________ □**High Cholesterol** □**Depression**

□**Arthritis** Type: ______________ □**Kidney Disease** □**COPD** □**Dementia**

Have you ever been exposed to excessive noise at home or work? □ Yes □ No

Patient Consent and Acknowledgment of Receipt of the Notice of Privacy Practice

This patient consent is for use and disclosure of protected health information.

With my consent, Mountaineer Audiology, LLC (MA) may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. Please refer to MA's Notice of Privacy Practices for a more complete description of such uses and disclosures. I hereby accept all responsibility for treatment costs not covered by or reimbursed by third party payers. I understand that the phrase "signature on file" will be indicated in the space for beneficiary's signature on Medicare or other insurance claim forms for the purpose of identifying applicable claims.

I have the right to review the Notice of Privacy Practices prior to signing this consent. MA reserves the right to revise its Notice of Privacy Practices at any time. Any future revision of the Notice of Privacy Practices may be obtained by forwarding a written request to Mountaineer Audiology, 25029 Northwestern Pike, Romney, W.V. 26757.

With my consent, MA may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder cards and patient statements as well as other correspondence.

With my consent, MA may give medical information about the patient to the alternate contact. The alternate contact can also consent to medical treatment and decision making on behalf of the guardian.

By signing this form, I am consenting to MA's use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations as described in our office's Notice of Privacy Practices that 1 have received. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, MA may decline to provide treatment.

_______ (initial here) By initialing this section and signing below, I authorize Mountaineer Audiology to send me educational and /or marketing information on the products and services offered by Mountaineer Audiology. No renumeration is involved in this communication. I understand that I may revoke this authorization, in writing; at any time.

______________________________ ______________

Signature of Patient or Legal Guardian/Parent | Date

______________________________ ______________

Print Name of Patient or Legal Guardian/Parent | Telephone

______________________ ______________________ ______________

Alternate Contact if Parent/guardian unavailable | Relationship to Patient | Telephone

I authorize Mountaineer Audiology ,LLC, to disclose my health information that is directly related to my current treatment at Mountaineer Audiology, LLC, to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

Name ______________________ Relationship ______________________

Mountaineer Audiology, LLC
Effective June 2, 2014

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices apply Mountaineer Audiology, LLC. All of the entities will share personal health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to personal health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make a new Notice effective for all personal health information maintained by Select Medical Corporation. We are also required to inform you that there may be a provision of State law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act. A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer, Mountaineer Audiology, LLC, 25029 Northwestern Pike Road Romney, West Virginia 26757

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

Authorization and Consent: Except as outlined below, we will not use or disclose your personal health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization.

Uses and Disclosures for Treatment: With your agreement, we will make uses and disclosures of your personal health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history etc.

Uses and Disclosures for Payment: With your agreement, we will make uses and disclosures of your personal health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations: With your agreement, we will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and patient care.

Individuals Involved In Your Care: With your written agreement we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with involved individuals without your approval. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment reminders or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You may make your requests by sending your name and address to Privacy Officer, 25029 Northwestern Pike Romney, West Virginia 26757.

Research: In limited circumstances, we may use and disclose your personal health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional review board which oversees the research or by representations of the researchers that limit their use and disclosure of patient information.

Other Uses and Disclosures:
We are permitted and/or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization for the following:

- any purpose required by law.
- public health activities, such as required reporting of disease, injury, birth and death, or required public health investigations.
- if we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect, or domestic violence.
- to the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls.
- to your employer when we have provided health care to you at the request of your employer;
- to a government oversight agency conducting audits, investigations, or civil or criminal proceedings.
- court or administrative ordered subpoena or discovery request;
- to law enforcement officials as required by law to report wounds and injuries and crimes;
- to coroners and/or funeral directors consistent with law;
- if necessary to arrange an organ or tissue donation from you or a transplant for you;
- if you are a member of the military; we may also release your personal health information for national security or intelligence activities; and
- to workers' compensation agencies for workers' compensation benefit determination.

RIGHTS THAT YOU HAVE REGARDING YOUR PERSONAL HEALTH INFORMATION:

Access to Your Personal Health Information
You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person.

Amendments to Your Personal Health Information
You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, must be in writing, signed by you or your legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records.

Accounting for Disclosures of Your Personal Health Information
You have the right to receive an accounting of certain disclosures made by us of your personal health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Personal Health Information: You have the right to request restrictions on uses and disclosures of your personal health information for treatment, payment, or health care operations. We are not required to agree to your restriction request, but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the individual responsible for medical records.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer, Mountaineer Audiology, LLC 25029 Northwestern Pike Romney, West Virginia 25757. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

Workers' Compensation: Medical information generated for services provided to Workers' Compensation patients is not covered by HIPAA. As such, Workers' Compensation patients do not have the right to restrict, amend or request an accounting of their Personal Health Information generated for purposes of Workers' Compensation.

FOR FURTHER INFORMATION: If you have questions or need further assistance regarding this Notice, you may contact the Privacy Officer, Mountaineer Audiology, LLC, 25029 Northwestern Pike Romney, West Virginia 26757.

______________________________ ______________________________

Patient Signature **Date**

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Patient Information

Patient's Name ______________________________
First / Initial / Last

Address ______________________________

City ______________ **State** ______ **Zip Code** ______

Home Phone ______ **Work Phone** ______ **Mobile Phone** ______ **Primary:** ☐ H ☐ W ☐ M

Social Security # ______ **Date of Birth** ______ **Sex** M F (circle) **Email** ______

Marital Status Married Single Other (circle) **Employment Status** FullTime PartTime None (circle) **Occupation** ______

Referring Physician ______ **Primary Physician** ______

Emergency Contact ______ **Phone** ______

How would you like to receive Appointment Notifications? ☐ Telephone ☐ Text ☐ Email ☐ None

Primary Insurance Information

(if patient is also the insured, enter 'SAME' for name & address)

(Office only): Insurance Card copy on file? ______

Insured's Name ______________________________ **Insured Date of Birth** ______
First / Initial / Last

Address ______________________________

City ______ **State** ______ **Zip Code** ______

Home Phone ______ **Work Phone** ______

Patient Relation to Insured Self Spouse Child Other (circle) **Insured Sex** M F (circle)

Other Insurance? ☐ ***YES*** ☐ **NO**

Insurance cards must be presented at time of appointment.

Responsibility Agreement: Copayment or payment in full is expected on the date of service is rendered. Payment of fee for service is your responsibility. Our office will assist you with insurance where applicable. Maryland Medical Assistance does not cover our services if you are 21 years of age or older. We do no participate with WV or PA Medical Assistance. Please ask our receptionist about our policies for Medical Assistance.

A finance charge of 1.5% per month is placed on all accounts after 30 days from the date of service, or 30 days from date insurance payment is received.

I have read and understand the above statements and agree to the conditions set forth. I accept financial responsibility for the fee for service. I certify the above information is true and correct to the best of my knowledge. I will notify you of any change in my health status or the above information.

I authorize any holder of medical or other information about me to release any information needed to process this or other claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Signed ______________________________ **Date** ______