INTEGRATIVE COUNSELING & WELLNESS NEW PATIENT PACKET

HEUSER INTEGRATIVE COUNSELING & WELLNESS CLINIC

We are now accepting new patients for telehealth and video counseling, wellness and Community Health Navigation openings.

Call for an appointment: 502-536-9280 or email bmartin@thehearinginstitute.org

Enrollment Date: _____ Referred By: _____

WHO WE ARE

Heuser Hearing Institute's Integrative Counseling & Wellness Clinic provides patient-centered assessment, diagnosis, counseling and integrative healing therapy approaches for individuals, families, caregivers and groups to cope with the stress and practical challenges of life, hearing loss and issues related to hearing and ear health.

We offer a number of services that include the following:

- Anxiety, depression, grief/loss, PTSD
- Cancer treatment and survivorship
- Caregiver support
- Dementia and hearing loss
- Dizziness
- Parents of children diagnosed with hearing loss
- Pain management: Non-pharmaceutical alternatives
- Palliative care, hospice, loss, and grief
- Sudden or progressive illness
- Tinnitus
- Traumatic brain injury
- Trauma-informed care

ONCOLOGY PATIENTS

Patient-centered services offered for those who are in active cancer treatment and/or afterward in the survivorship phase and who lose their hearing as a result of (cisplatin or platinum-based chemotherapy), and those who experience hearing loss, aural neuropathy or auditory processing issues after chemo, radiation, or surgery of the head and neck.

PARENTS, CAREGIVER, FAMILY: INDIVIDUAL AND GROUP SESSIONS

Offered for those who support loved ones with hearing loss providing access to other Heuser Hearing Institute resources, Community resources and referrals, information, technical assistance, advocacy, classes, workshops and therapy for grief, loss and finding balance in new living a healthy, happy life, coping with hearing loss or other issues related to hearing and ear health.

***PATIENTS WHO ARE DEAF AND BLIND RECEIVE ASSESSMENT, DIAGNOSIS AND THERAPY 1:1 WITH A THERAPIST WHO CAN SIGN DIRECTLY, OR IF REQUESTED, THROUGH A SIGN LANGUAGE INTERPRETER.**

Our Heuser Integrative Counseling and Wellness Clinic is here to serve patients via Telehealth and Video Remote sessions during times of healthcare emergencies.

Call (502) 536-9280 or email to: bmartin@thehearinginstitute.org to set up an appointment.

CONTACT INFORMATION:

Appointments: 502-584-3573

Fax: 502-583-6364—Downtown

TDD: 502-515-3319

Email: info@thehearinginstitute.org

www.thehearinginstitute.org

CONTENTS:

- Client Information
- Billing Information
- Release Form
- Patient Agreement & Authorization Form
- Notice of Privacy Information

JUST A REMINDER

You are scheduled for an appointment on:

Date: _____

Time: _____

CENTER:

Downtown Center

LOCATIONS:

Downtown

117 E Kentucky St.

Louisville, KY 40203

CLIENT INFORMATION

1. Full Name: _____
   (first) (middle) (last)
2. Address: _____
   (street) (city) (state) (zip)
3. Date of Birth: _____/_____/_____
4. Gender: _____
5. Social Security Number: _____
6. Primary Phone Number: _____
7. Email Address: _____
8. Work Status (check): ☐ Full-time ☐ Part-time ☐ Retired/Unemployed
9. Employer (if applicable): _____
10. Work Phone (if applicable): _____
11. Emergency Contact: _____
12. Relationship to Client: _____
13. Address of Party Identified In Question 15: _____
    (street) (city) (state) (zip)
14. Primary Phone of Party Identified In Question 15: _____
15. Work Phone: _____ Cell Phone: _____
16. Primary Care Physician/Phone: _____
17. Other Medical Professional(s)/Phone: _____
18. Other Medical Professional(s)/Phone: _____
19. Do you consider yourself Hispanic? ☐ Yes ☐ No
20. Do you consider yourself primarily:
    - ☐ Black
    - ☐ American Indian/Native American
    - ☐ Asian
    - ☐ White
    - ☐ Native Hawaiian or Pacific Islander
    - ☐ Other
21. Language Preference: _____
22. Do you have difficulty reading English? ☐ Yes ☐ No
23. Is English your native language? ☐ Yes ☐ No
24. Please state your primary language _____

25. Your monthly family income before taxes: _____

_____ Cannot recall before taxes, reported after taxes

- ☐ 0 – 1,000
- ☐ 1,00 – 12,000
- ☐ 2001 – 3000
- ☐ 3,001 – 4,000
- ☐ 4,001 – 5,000
- ☐ 5,001 – 6,000
- ☐ 6,001 –7,000
- ☐ 7,001 – 8,000
- ☐ 8,001 – 9,000
- ☐ 9,001 – 10,000
- ☐ 10,001 – 12,000
- ☐ 12,001 – 15,000
- ☐ 15,001 – 18,000
- ☐ 18,001 – 21,000
- ☐ 21,000 – Above
- ☐ Not reported

26. Does your budget include (check):

- ☐ Food stamps
- ☐ Social security
- ☐ Church support
- ☐ SSI
- ☐ Retirement savings
- ☐ Other health-related earnings
- ☐ Veteran benefits
- ☐ Food pantries
- ☐ Other: _____

27. Marital Status: (check):

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ A Member of an Unmarried Couple

28. Cultural/Religious/Spiritual: _____

29. Do you have any customs, religious beliefs or wishes that might affect your care? ☐ Yes ☐ No

30. With whom do you live:

- ☐ Alone
- ☐ Spouse/Partner only
- ☐ Spouse/Partner and others
- ☐ Child, not spouse
- ☐ Other relatives, not spouse or children
- ☐ Group setting
- ☐ Personal care attendant
- ☐ Other: _____

31. Do you have a caregiver? ☐ Yes ☐ No (If YES, please list) _____

_____
Relationship Name

32. Can you drive a car alone? ☐ Yes ☐ No

33. Do you have access to a car that you can use to get around beyond just to medical appointments?
☐ Yes ☐ No

34. Employment History:
☐ Retired (previous employer/type of work): _____
☐ Working part-time in home/homemaking
☐ Working part-time outside of home (employer/type of work): _____
☐ Working full time (employer/type of work): _____
☐ Volunteering (agency): _____
☐ Other: _____

35. Did you serve in the military? ☐ Yes ☐ No

36. What is your highest year of school completed?

1 2 3 4 5 6	8 9 10 11 12	13 14 15 16	17 18 19 20 21 22 23+
(Primary)	(High School)	(College)	(Graduate School)

37. Have you completed an Advance Directive or Living Will? ☐ Yes ☐ No

38. If no, are you interested in learning more about Advance Directives? ☐ Yes ☐ No

39. Have you completed a Power of Attorney? ☐ Yes ☐ No

40. If no, are you interested in learning more about a Power of Attorney? ☐ Yes ☐ No

41. What services are you receiving from Area Agencies on Aging and/or Independent Living:
(check all that apply)
☐ Peer Mentoring Program
☐ Wheels/Transportation Assistance
☐ Caregiver Support
☐ HomeCare
☐ Falls Prevention
☐ Meals/Nutrition Support
☐ Medicare/Medicaid counseling or SHIP Counseling
☐ HomeMeds, a medication management program
☐ Senior Center participation
☐ Other:

42. Do you require any special language accommodations? Check one: ☐ Yes ☐ No

43. Please indicate your language or signed modality of choice (Check any that apply):

- ☐ ASL
- ☐ PSE
- ☐ SEE
- ☐ Cued Speech
- ☐ CART
- ☐ TASL
- ☐ Tracking
- ☐ Close Vision
- ☐ Limited Field

Assistive Listening Device Type: _____

_____

Or

Foreign Language: _____

_____

44. Notes: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Person completing form Date

HEUSER HEARING INSTITUTE INSURANCE BILLING INFORMATION

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

Patient's Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

Alternate Phone: _____ Social Security No: _____

Referring Physician First Name: _____ Last Name: _____

Address/Phone: _____

Primary Care Physician First Name: _____ Last Name: _____

Address/Phone: _____

Emergency Contact: _____ Phone: _____

E-Mail Address: _____

- ☐ **YES** – I would like to be kept up-to-date on hearing devices, technology, and happenings around our office and campus.
- ☐ **YES** – I would like to receive the "Good Vibrations" newsletter.

BELOW INFORMATION IS NEEDED TO FILE INSURANCE

Responsible Party or Father's Name: _____

Responsible Party or Mother's Name: _____

Employer: _____ Work Phone: _____

Employer: _____ Work Phone: _____

Primary Insurance: _____ Group No.: _____

Subscriber's Name: _____ I.D. No.: _____

Date of Birth: _____

Secondary Insurance: _____ Group No.: _____

Subscriber's Name: _____ I.D. No.: _____

Date of Birth: _____

Please check any of the following methods that apply to your coverage:

☐ Self-Pay ☐ Insurance filed by patient ☐ Disability Determinations

☐ Insurance Filed by Heuser Hearing Institute ☐ Referred by Vocational Rehabilitation

Other (Please explain) _____

I hereby authorize the release of medical information or other information acquired during the course of examination and treatment to insurance carriers, physicians, or my legal representatives. I hereby request payment of benefits from all insurance carriers to The Heuser Hearing Institute. I understand I am responsible for and will pay any amount not covered by insurance, including collection costs and reasonable attorney fees if referred for collection. I understand that I am responsible for all referrals to be sent to Heuser Hearing Institute prior to any services being rendered. I understand that as a Medicaid recipient and over the age of 21 years, I am fully responsible for my bill.

SIGNATURE: _____ DATE: _____

PATIENT AGREEMENT AND AUTHORIZATION FORM

Thank you for choosing Heuser Hearing Institute as your hearing health care provider. Payment for services and products is due at the time of service. Our office accepts cash, personal checks, Mastercard, Visa, and Discover. Heuser Hearing Institute participates with many insurance companies. As a courtesy to you, we will file your claim with your insurance company (we will file primary and secondary, filing of tertiary or other insurance is the patient's responsibility).

We thank you for the opportunity to serve your hearing health care needs and welcome any questions you may have concerning your care or our financial policies.

PATIENT AGREEMENTS AND AUTHORIZATIONS:

I hereby authorize Heuser Hearing Institute to release personal healthcare information, which is necessary in order to process any insurance claim. I authorize the assignment of insurance benefits to Heuser Hearing Institute. This assignment will remain in effect until revoked in writing.

_____ **I understand that I am financially responsible to Heuser Hearing Institute for any charges incurred for services performed or products dispensed regardless of insurance coverage.**

I understand that it is my responsibility to be informed regarding my insurance coverage. I understand that it is my responsibility to furnish this office with current insurance information should there be any change in my insurance coverage. All patients whose insurance requires a referral for treatment must have a current referral in order to be seen. I understand that it is my responsibility to obtain any required referrals prior to the date of my appointment. Failure to do so may result in the denial of my claim by the insurance carrier, in which case I will be fully responsible for all charges.

I understand that my account must be kept current and that any past due balances are due prior to my next visit. I agree that I will pay all collection agency costs, attorney's fees, collections fees and contingent fees if my account is placed for collection. I understand that if my account goes to a collection agency that I may be dismissed as a patient, in which case I will not be able to receive treatment from any of the staff of Heuser Hearing Institute.

A copy of the facsimile of this document is considered equivalent to the original.

I have read, understand, and agree with the above terms and conditions in their entirety.

Patient signature (or legal guardian): _____ Date: _____

I was given a copy of this signed agreement: _____ Staff initials: _____

Patient Name: _____

NOTICE OF PRIVACY PRACTICES (EFFECTIVE APRIL 14, 2003)

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

The federal law called the Health Insurance Portability and Accountability Act of 1993 (#HIPAN) creates certain rights for our patients. One of those is a right to information regarding our privacy practices. Under federal regulations, we must provide you with a copy of this Notice of Privacy Practices and ask that you sign an acknowledgment that we gave the notice to you. You may review the Notice of Privacy Practices immediately or later. At some point, you should read it carefully because it explains:

- Generally, how we use health information about you;
- That we, like other health care providers, may use and disclose health information about you as part of your treatment to arrange for payment for services provided and for our internal operations. We are not required to have separate permission for these uses and disclosures;
- Other circumstances where we may use or disclose information about your health where we are not required to get your permission first;
- The rights you have with respect to health information we have about you, including:
- Your right to have a copy of this privacy notice;
- Your right to review and copy health information that we may have about you;
- Your right to an accounting for how we use and disclose your health information, other than for treatment, payment or health care operations;
- Your right to request that we communicate with you at alternative locations, mailing address or telephone numbers;
- Your right to request restrictions on how we use your health care information;
- Your right to request an amendment to information in our records that you think is an error;
- Your right to file a complaint if you think your privacy rights have been violated.

Acknowledgment of Receipt: I acknowledge receiving a copy of the Notice of Privacy Practices for Heuser Hearing Institute and Heuser Hearing and Language Academy this _____ day of _____, 20_____.

Signature: _____

Please Print Name: _____

(If not the patient)

If you are not the patient, state your relationship: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

I hereby authorize Heuser Hearing Institute to ☐ Release To or ☐ Release From (Please Check One)

Please list below person or entity records are to be disclosed to:

_____

_____

_____

If you would like us to share your medical information with the University of Louisville researchers, please check here: ☐ Yes ☐ No

I authorize the following protected health information to be released: (Specific description of portions of records to be released. e.g., clinic dictation, hearing testing, vestibular testing, diagnostic testing, educational information, psychological information, social and development treatment plans, therapy notes, etc. and time periods of information to be released).

This authorization for use and disclosure is for the following purpose:

I understand that the medical record release pursuant to this authorization could contain information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, or blood-borne infectious diseases, which are subject to federal or state restrictions on disclosure. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

I understand that I do not have to sign this authorization and that Heuser Hearing Institute may not condition treatment or payment on whether I sign this authorization. However, I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter to Heuser Hearing Institute at the address listed on this authorization form. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and disclose my protected health information have acted in reliance upon this authorization.

Unless otherwise revoked, I understand that this authorization will expire one hundred and eighty (180) days from the date of this form or on the following date or event:

_____ _____

Signature of Patient or Legal Guardian Date

_____

Printed Name of Patient Representative given authority to act for Patient

_____

Relationship to Patient

MEDICATION LIST *(ALL PATIENTS)*

NAME: _____ DOB: _____

Please be sure to include ALL prescription drugs, over-the-counter drugs, vitamins and herbal supplements.

	What I'm Taking	**Form** *(pill, injection, liquid, patch, etc.)*	**Dosage**	**How Much & When**	**Use** *(regularly or occasionally)*	**Start/Stop Dates** *(11/5/15 - 3/10/16 or 11/5/15 - ongoing)*	**Notes, Directions, Reasons for Use**
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

INFORMED CONSENT FOR TELETHERAPY

This Informed Consent for Teletherapy contains important information concerning engaging in electronic psychotherapy or teletherapy. Please read this carefully and let me know if you have any questions. This consent shall only apply to clients physically within the Commonwealth of Kentucky seeking therapeutic treatment within the Commonwealth of Kentucky. This Informed Consent shall be signed in conjunction with The Heuser Hearing Institute, Inc. Integrative Counseling & Wellness Clinic Enrollment Packet and Patient Agreement and Authorization forms.

BENEFITS AND RISKS OF TELETHERAPY

Teletherapy refers to the remote provision of psychotherapy services using telecommunications technologies such as video conferencing or telephone. One of the benefits of teletherapy is that the client and therapist can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or therapist moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It can also increase the convenience and time efficiency of both parties.

Although there are benefits of teletherapy, there are some fundamental differences between in-person psychotherapy and teletherapy, as well as some inherent risks. For example:

- Risks to confidentiality. Because teletherapy sessions take place outside of the typical office setting, there is potential for third parties to overhear sessions if they are not conducted in a secure environment. I will take reasonable steps to ensure the privacy and security of your information, and it is important for you to review your own security measures and ensure that they are adequate to protect information on your end. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.
- Issues related to technology. There are risks inherent in the use of technology for therapy that are important to understand, such as: potential for technology to fail during a session, potential that transmission of confidential information could be interrupted by unauthorized parties, or potential for electronically stored information to be accessed by unauthorized parties.
- Crisis management and intervention. As a general rule, I will not engage in teletherapy with patients who are in a crisis situation. Before engaging in teletherapy, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our teletherapy work.
- Efficacy. While most research has failed to demonstrate that teletherapy is less effective than in-person psychotherapy, some experienced mental health professionals believe that something is lost by not being in the same room. For example, there is debate about one's ability when doing remote work to fully process non-verbal information. If you ever have concerns about misunderstandings between us related to our use of technology, please bring up such concerns immediately and we will address the potential misunderstanding together.

ELECTRONIC COMMUNICATIONS

We will discuss which is the most appropriate platform to use for teletherapy services. I will do my best to comply with the American Counseling Association's Ethics Code guidance on Distance Counseling as well as the Colorado Department of Regulatory Agency's Teletherapy Policy, and I will provide you with a copy of these guidelines upon request.

You may be required to have certain system requirements to access electronic psychotherapy via the method we choose. You are solely responsible for any cost to you to obtain any additional/necessary system requirements, accessories, or software to use electronic psychotherapy.

For communication between sessions, I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement.

That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not include any clinical material by email and prefer that you do not as well.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions, however, if an urgent issue arises, you should feel free to attempt to reach me by phone. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I am unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

CONFIDENTIALITY

I have a legal and ethical responsibility to do my best to protect all communications, electric and otherwise, that are a part of our teletherapy. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that a third party may not gain access to our communications. Even though I may utilize state-of-the-art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic communications may be compromised, unsecured, or accessed by a third party.

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Disclosure Statement and Informed Consent for Services still apply in teletherapy. Please let me know if you have any questions about exceptions to confidentiality.

APPROPRIATENESS OF TELETHERAPY

If at any time while we are engaging in teletherapy, I determine, in my sole discretion, that teletherapy is no longer the most appropriate form of treatment for you, we will discuss options of engaging in face-to-face in-person counseling or referrals to another professional in your location who can provide appropriate services.

EMERGENCIES AND TECHNOLOGY

Assessing and evaluating threats and other emergencies can be more difficult when conducting teletherapy than in traditional in-person therapy. In order to address some of these difficulties, I will ask you where you are located at the beginning of each session, and I will ask that you identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session cuts out, meaning the technological connection fails, and you are having an emergency, do not call me back, but call 911, the National Suicide Hotline at 800-273-TALK (8255), or go to your nearest emergency room. Call me after you have called or obtained emergency services.

If the session cuts out and you are not having an emergency, disconnect from the session, and I will wait two (2) minutes and then re-contact you via the teletherapy platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me on the phone number I provided you (502-536-9280).

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

FEES

The same fee rates shall apply for teletherapy as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted using electronic psychotherapy. If your insurance, HMO, third-party payer, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in teletherapy sessions in order to determine whether these sessions will be covered.

INFORMED CONSENT

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together. Your signature below indicates agreement with its terms and conditions. This agreement is supplemental to my general informed consent and does not amend any of the terms of that agreement.

I, _____, the client, having been fully informed of the risks and benefits of teletherapy; the security measures in place, which include procedures for emergency situations; the fees associated with teletherapy; the technological requirements needed to engage in teletherapy; and all other information provided in this informed consent, agree to and understand the procedures and policies set forth in this consent.

_____ _____

Signature of Client Date

_____ _____

Signature of Therapist Date

HOW CAN WE HELP?

Name (optional): _____

Date: _____

Who is completing this form today?

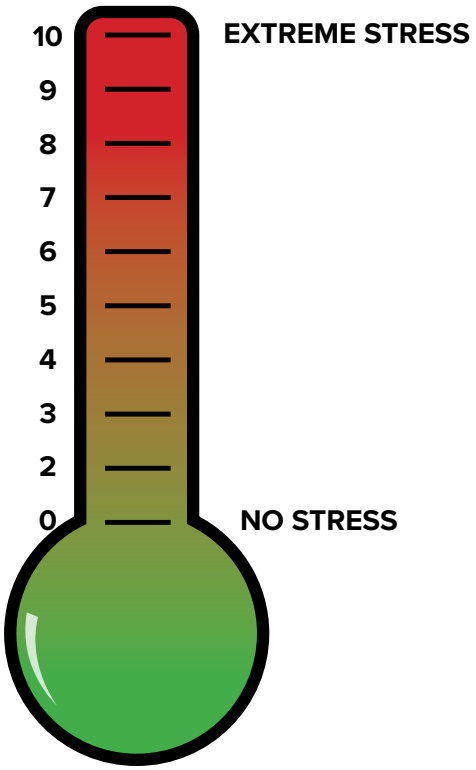
Please check one:

- ☐ Patient (self)
- ☐ Family member/caregiver
- ☐ Non-family member/caregiver
- ☐ Heuser visitor

Department of Social Services (502) 584-3573 ext. 1102

Please take a moment to complete the front of this form. By turning in the form prior to your appointment, even if you have no problems or concerns and consider your stress level to be a "0" at this time, you allow us to collect information specific to people with ear-related problems in our community which will help us customize care and optimize research.

Instructions: Please circle the number (0–10) that best describes how much stress you have been experiencing in the past week, including today.



PROBLEM LIST

Please indicate if any of the following has been a problem for you in the past week, including today. Be sure to check all that apply.

- ☐ **Practical Problems**
  - ☐ Childcare
  - ☐ Disability/Accessibility
  - ☐ Food/Clothing/Housing insurance/Financial/Legal
  - ☐ School/Academics/Social isolation
  - ☐ Transportation
  - ☐ Work
- ☐ **Family Problems**
  - ☐ Caregiver concerns
  - ☐ Dealing with relationships
  - ☐ Family health issues
  - ☐ Parental support/Needs
  - ☐ Safety
- ☐ **Emotional Problems**
  - ☐ Depression\Sadness fatigue
  - ☐ Fears
  - ☐ Nervousness
  - ☐ Worry
  - ☐ Loss of interest in usual activities
- ☐ **Spiritual/Religious Concerns**
- ☐ **Ear Health Concerns**
  - ☐ Balance issues
  - ☐ Changes in hearing
  - ☐ Difficulty coping with hearing loss
  - ☐ Dizziness/Vertigo
  - ☐ Earaches
  - ☐ Ear drainage
  - ☐ Ear fullness/Pressure
  - ☐ Ear/Nose/Throat problems
  - ☐ Follow-up to newborn hearing screening
  - ☐ Hearing loss due to cancer treatment
  - ☐ Hearing loss due to other medical condition or treatment
  - ☐ Hearing loss due to high fever
  - ☐ Hearing changes after stroke
  - ☐ Memory/concentration
  - ☐ Nausea
  - ☐ Pain
  - ☐ Ringing in the ears/Tinnitus
  - ☐ Social/Emotional problems
  - ☐ Speech impairment
  - ☐ Sudden hearing loss
- ☐ **Other Health-Related Concerns**
  - ☐ Addiction/Substance abuse
  - ☐ Dental and vision
  - ☐ Pain management
  - ☐ Treatment decisions

At Heuser Hearing Institute, we want to make sure our patients are aware of all services our specialists are able to provide to assist in meeting your unique needs.