HEUSER HEARING INSTITUTE
Hearing & Language Academy

NEW PATIENT PACKET

JUST A REMINDER

You are scheduled for an appointment on:

Date _____ Time _____

☐ Old Louisville
117 E Kentucky Street
Louisville, KY 40203

☐ Breckenridge
2932 Breckenridge Lane
Suite 1
Louisville, KY 40220

☐ Lyndon
417 Benjamin Lane
Suite 202
Louisville, KY 40222

☐ Masonic Home
240 Masonic Home Drive
Masonic Home, KY 40041

**Please arrive 15 minutes prior to your appointment time.*

**Please fill out all the enclosed forms and bring them with you to your appointment.*

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HEUSER HEARING INSTITUTE CONTACT INFORMATION:

Appointments: (502) 584-3573

Fax: (502) 583-6364

Email: info@thehearinginstitute.org

www.thehearinginstitute.org

PEDIATRIC CASE HISTORY

Name _____ Date _____

DOB _____ Gender ☐ Male ☐ Female

Address _____ Phone _____

Person Completing Form _____ Relationship _____

Mother _____ Father _____

Birth Hospital _____

Who referred you to our center? _____

Reason for visit or concern_____

_____

_____

Has your child been seen by other medical/hearing professionals about your concern? If so, please list.

Professional _____ Address _____ Date _____

Professional _____ Address _____ Date _____

Professional _____ Address _____ Date _____

Professional _____ Address _____ Date _____

What were the results of the above listed evaluations? _____

_____

_____

Pediatrician _____ Address _____

ENT Physician _____ Address _____

Do you or your child have special needs, including allergies, or require assistance to help us prepare for this evaluation? If so, please describe: _____

_____

_____

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BIRTH HISTORY

Length of Term _____ Child's Birth Weight _____

Describe any difficulties that you or your child experienced during labor or delivery. _____

_____

_____

Are you aware of any conditions that would make your child "at risk" for hearing difficulties? _____

_____

_____

MEDICAL HISTORY

Has your child had any recent or chronic illnesses? ☐ Yes ☐ No

If yes, explain: _____

_____

_____

Does your child take any medications? ☐ Yes ☐ No

If yes, explain: _____

_____

_____

AUDITORY DEVELOPMENT

At what age did you suspect that your child had a hearing loss? _____

What is the cause, if known, of the hearing loss? _____

Is there a family history of hearing loss? ☐ Yes ☐ No

If yes, explain: _____

_____

_____

Does your child wear hearing aids? ☐ Yes ☐ No Make _____ Model _____

Ear(s) aided: ☐ Right ☐ Left ☐ Both Date of first fitting _____ Audiologist _____

Does your child wear the aids every waking hour or selectively? _____

What sounds does your child respond to unaided? _____

What sounds does your child respond to aided? _____

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COMMUNICATION SKILLS

Does your child use words, sounds and/or gestures to communicate? Please describe: _____

_____

_____

Do you use primarily words, signs and/or gestures to communicate with your child? Please describe: _____

_____

_____

How does your child typically communicate his/her wants or needs? _____

_____

_____

Has your child received speech-language therapy before? ☐ Yes ☐ No

If yes, then where? _____

What percent of the time do you feel you understand your child? _____ %

What percent of the time do you feel unfamiliar people understand your child? _____%

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 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 (primary and secondary only; 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 health care information, which is necessary in order to process my insurance claim. I authorize 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, 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 to 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, 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.

_____ IF I am a Medicaid recipient and over the age of 21 years, I understand I am no longer eligible for hearing health care under the Medicaid program and am fully responsible for my bill.

A copy or 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: _____

HEUSER HEARING INSTITUTE
Hearing & Language Academy

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 AN INSURANCE CLAIM

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 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 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 _____

HEUSER HEARING INSTITUTE
Hearing & Language Academy

Authorization for Release of Protected Health Information

Patient Name: _____ DOB: _____

I hereby authorize Heuser Hearing & Language Academy 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/development, treatment plans, therapy notes, etc. and time periods of information to be released).

This authorization for use/ 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 and/or blood borne infectious diseases, which are subject to federal and/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/or 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/event:

_____ _____
Signature of Patient/ Legal Guardian Date

_____ _____
Printed Name of Patient Representative given authority to act for patient Relationship to patient

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 ("HIPAA") 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 acknowledgement 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.

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

Signature: _____

Please Print Name: _____

(If not the patient)

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

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.

Heuser Hearing Institute (HHI) and the Louisville Deaf Oral School (LDOS) are required by law to maintain the privacy of your protected health information. "Protected health information" is intonation about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health services. We are also required to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.

This notice describes and gives examples of how we may use or disclose your protected health information for various purposes. These examples are not a complete list of all possible uses and disclosures. We may make additional uses and disclosures of your protected health information in any manner that is consistent with this Notice. This Notice also describes your rights to access and control your protected health information.

The practice is required to abide by the terms of its Notice of Privacy Practices currently in effect. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that we maintain. If we change our Notice of Privacy Practices, we will post the revised Notice in a clear and prominent place in our office and make a copy available to you upon request.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR THE TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Your protected health information may be used and disclosed for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to obtain payment of your health care bills and support the operation of this practice.

The following are some examples of the types of uses and disclosures of your protected health care information that the practice may make.

TREATMENT: We may use and disclose your protected health information to provide, coordinate or manage your hearing health care and any related services. This includes coordinating your health care with a third party. For example, we might disclose your protected health information to a home health agency that provides care to you or to other physicians, nurses and therapists who may be treating you and to laboratories that provide testing for our patients. If you are a student at LDOS or a school where we provide contract services, we may disclose your child's protected health information to educators involved in your child's education.

PAYMENT: Your protected health information may be used and disclosed to obtain payment for your health care services. This may include sharing information with your health insurance plan as it makes payment decisions, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. We may also use and disclose protected health information for the payment activities of another health care entity or provider.

HEALTH CARE OPERATIONS: We may use or disclose your protected health information in order to support the business and administrative activities of this practice. These activities may include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities and conducting or arranging other business activities.

For example, we may disclose your protected health information to medical/graduate school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your hearing health care professional. We may also call you by name in the waiting room when your health care professional is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may also disclose your protected health information to another entity covered by similar privacy requirements in order for that entity to conduct specific health care operations, which include quality assessment activities and reviewing the competence of health care professionals. We will share your protected health information with third party "business associates" that perform various activities

for the practice (e.g. billing, transcription services, legal and accounting). However, we will require each business associate to give us written assurances that it will protect the privacy of your protected health information.

We may use or disclose your protected health information to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. You may contact out Privacy Officer at (502) 584-3573 to request that these materials be sent to you.

ADDITIONAL DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT

In addition to the circumstances described above, we may use or disclose your protected health information in the following situations without your authorization:

REQUIRED BY LAW: We may disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirement of the law.

USE AND DISCLOSURES THAT MAY BE MADE WITH YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your protected heath information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke such an authorization at any time in writing, except the extent that your hearing health care professional or our clinic has taken an action in reliance on the use or disclosure indication in the authorization.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

- With certain exceptions, you have the right to inspect and copy your protected health information that is contained in a designated record that we maintain. A "designated record set" contains medical and billing records and any other records that your hearing health care professional and our clinic uses for making decisions about you. You do not have a right to inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to a law that prohibits your access. Depending on the circumstances, a decision to deny your access may be reviewable. Please contact our HIPAA Contact Officer at (502) 515-3320 ext. 291 if you have questions about access to your health information.

- You have the right to request that we restrict the use or disclosure of your protected health information for the purpose of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or disaster relief notification purposes. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree with your request. If we do agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment or its use or disclosure required by law.

- If you want to request a restriction, it must he made in writing to our HIPAA Contact Officer at 115 East Kentucky Street, Louisville, KY 40203. Your request must describe in clear and concise fashion; (A) the information you wish restricted; (B) whether you are requesting to limit our clinic's use, disclosure or both; and (C) to whom you want the limits to apply.

- You have the right to request that confidential communication from us be sent by alternative means or to an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information on how payment will be handled or specifications of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Contact Officer.

- You may have the right to have your hearing health care professional amend your protected health information contained in a file that we maintain. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement. If we do, we will provide you with a copy of that rebuttal. Please contact our Privacy Officer if you have questions about amending your health information.
- You have the right to receive an accounting of certain disclosures of your protected health information that we may make after April 14, 2003. This right is subject to certain exceptions and limitations. Among other exceptions, it does not apply to disclosures for purposes of treatment, payment or health care operation as described in this Notice to disclosures made pursuant to your authorization; or disclosures made to you or individuals involved in your care.
- Even if you have agreed to accept this Notice electronically, you have a right to obtain a paper copy of this Notice upon request.

MAKING A COMPLAINT

You may complain to the Secretary of Health and Human Services or directly to us if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Contact Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Contact Officer at (502) 515-3320 ext. 291 for further information about the complaint process.

No-Show Policy

As a specialty practice, this office is a limited resource for this community. When patients fail to show for their scheduled appointment, it causes other patients to wait unnecessarily. Please consider the needs of the community, and reschedule your appointment in a timely fashion if needed.

LATE ARRIVAL AND FAILURE TO SHOW POLICY

ARRIVAL TIME: Please arrive for your appointment 15 minutes early as a courtesy to other patients and your provider. Please consider arriving 30 minutes early if you will need to complete history and billing information while in the office. Preparation and early arrival will help us provide your services in a timely manner.

LATE ARRIVAL POLICY: Because we all understand that the unexpected is bound to happen, please review our late arrival policy. If you arrive 15 minutes late for a 30-minute appointment, please expect to reschedule your appointment. If the 30-minute appointment is for equipment repair and/or consult, we will use the 30 minutes of your reserved appointment to solve problems if possible. We will not be able to provide patient care. If your appointment is scheduled for longer than 30 minutes, we will use your reserved appointment time for your assessment. Please be aware that exceptions may exist under certain circumstances (example: you have a 1-hour appointment that includes three subtests that are dependent upon one another for recommendations).

NO-SHOW POLICY: All patients will be granted a warning, notification and no strings attached re-scheduling for the first missed appointment. If a patient fails to keep two scheduled appointments, we will be happy to reschedule the appointment during clinic hours or on a first come first available basis (see our established policy).

Frequently Asked Questions Concerning the Infant Hearing Evaluation

WHAT TESTS ARE INCLUDED IN THE EVALUATION?

Auditory Brainstem Response (ABR) evaluates the function of the auditory system including the inner ear and auditory nerve. The ABR is frequently used with children and infants. Electrodes will be taped to the infant's ears and forehead and electrical activity from the auditory nerve will be measured. The test does not require your child to respond in any way. The test can be completed while your child is asleep or awake. The test will run more quickly while your child is relaxing and most quickly when your child is sleeping. Immediately prior to testing, a bottle may be given in order to help your child sleep. Otoacoustic Emissions (OAEs) evaluate the function of the inner ear but do not measure the amount of hearing. The test can be performed while your child is awake or sleeping. It is necessary for your child to be still and quiet for the evaluation. It typically takes 2-6 minutes to complete this test. Immittance testing evaluates the function of the middle ear and middle ear reflex. It is used to identify the presence or absence of fluid or middle ear dysfunction and to confirm previously obtained results. This test can be completed on a sleeping or awake infant. It is typically completed in less than three minutes.

WILL YOU BE ABLE TO OBTAIN RESULTS IF MY CHILD DOES NOT SLEEP? AND, WHAT ABOUT SEDATION?

Yes. All tests can be completed on awake or sleeping children. Each test is simply more efficient on a relaxed child. Heuser Hearing Institute does not use sedation. We have state-of-the-art equipment that allows us to complete the test battery on active babies and toddlers. In the event that your child is too active for testing, your evaluation can be rescheduled at a hospital where sedation can be made available. Heuser Hearing Institute audiologists will still complete the evaluation; we will just meet at the hospital. Sedation is required for less than one percent of our patients.

WHAT SHOULD I BRING?

Please bring a bottle and any other items (pacifier, blanket, etc.) that may help your child sleep. If you are breastfeeding, you can be left alone to feed your child prior to the test. Since the entire procedure may take 1-2 hours, please bring extra diapers and dress your child comfortably. For toddlers, please bring snacks (soft so chewing is not noisy), drinks, comfort toys and DVDs to help your child relax or sit quietly.