



BACKGROUND INFORMATION: HEARING

Date: _____ Name: _____ Birthdate: _____ Age: _____ M/F

Address: _____
Street/P.O. Box City State Zip Code

Telephone: _____
Home Work Other

May we contact you via email with news, updates and special promotions? YES NO
(Emails will only come from Savannah Speech & Hearing Center. We do not share our patient list.)

If YES, what is your email address? _____

- 1. Do you think you have a hearing loss? Yes ___ No ___ If Yes, cause and how long? _____
- 2. Do family members or others think you have a hearing loss? Yes ___ No ___
- 3. Problems hearing on the phone? Yes ___ No ___ If yes, which ear do you use on the phone? _____
- 4. Do others complain that you turn the TV up too loud? Yes ___ No ___
- 5. Do you struggle to understand speech in group situations or in the presence of background noise while others do not seem to have this problem? Yes ___ No ___
- 6. Family history of hearing loss? Yes ___ No ___ If Yes, describe: _____
- 7. Loud noise exposure? Work? Yes ___ No ___ Military? Yes ___ No ___ Hobby? Yes ___ No ___
- 8. Have you ever used a hearing aid? Yes ___ No ___ If yes, Which ear? Left ___ Right ___
- 9. If you do not now use a hearing aid, do you think you need one? Yes ___ No ___
- 10. Do family members or others think you need a hearing aid? Yes ___ No ___
- 11. Have you ever seen a physician who specializes in ear problems? Yes ___ No ___
If Yes, Who? _____ When? _____
- 12. Did anyone refer you here? Yes ___ No ___ If yes, who? _____
- 13. How did you hear about this service? _____
- 14. Have you had any of the following? Ear infections? ___ Ear pain? ___ Ear fullness? ___
Dizziness? ___ Ear drainage? ___ Excessive ear wax? ___ Ear sugery? ___ Ear noises? ___
If Yes, Please describe _____
When? _____ Which ear? left ___ right ___ both ___
- 15. Do you have: High Blood Pressure? ___ Diabetes? ___ Allergies? ___ If Yes, Describe: _____
List current medications, if any: _____
- 16. Describe current general health status: _____
- 17. Other comments or questions: _____
- 18. Would you like a copy of today's evaluation to be sent to your physician? Yes ___ No ___
Physician's Name: _____

Your signature here grants permission to treat: _____

Relationship to patient: _____

SPEECH & HEARING CENTER SAVANNAH

1206 East 66th Street, Savannah, GA 31404 ● Phone (912) 355-4601 ● Fax (912) 355-7935

INSURANCE / PAYOR INFORMATION

Patient's name as appears on policy: _____

Patient's Date of Birth: _____ Sex: M/F

Contact (if child): _____ phone home: _____

Hours can be reached at home - _____ phone work/cell: _____

Responsible party/bill to: _____

PRIMARY INSURANCE/Medicare

COPAY: \$ _____ **Insurance Referral Number:** _____

Insured/Policyholder's Name: _____

(who has the insurance)

Insured's Address: _____

(if different from the client)

Date of Birth (Policyholder's): _____ Insurance Company: _____

Member ID Number: _____ Employer: _____

(need the individual's identification number to file)

Relationship to Patient: _____ Date Coverage Began: _____

SECONDARY INSURANCE

Insured/Policyholder's Name: _____

(who has the insurance)

Insured's Address: _____

(if different from the client)

Date of Birth (Policyholder's): _____ Insurance Company: _____

Member ID Number: _____ Employer: _____

(need the individual's identification number to file)

Relationship to Patient: _____ Date Coverage Began: _____

MEDICAID or PEACHCARE

Name as it appears on the card:

Last: _____ First: _____ Middle Initial: _____

Recipient ID Number: _____

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INSURANCE / PAYOR INFORMATION (Continued)

Please understand that the primary goal of the Center is to provide service to the public. We attempt to work with our clients regarding obligations for services whether payment may be through insurance, private pay, co-payments or other arrangements.

If payment is not received from an insurance company within 3 months from the date billed or if a denial is received from an insurance company, we will be required to call upon you for payment. Should you choose to appeal the denial and win, you will be reimbursed by the Center any money owed to you. A finance charge of 1% will accrue if payment is not received by the Center within 30 days of the date you are billed.

ASSIGNMENT OF BENEFITS

I hereby authorize payment by my insurance carrier of the benefits, otherwise payable to me, to be made directly to **Savannah Speech and Hearing Center** for their services.

I certify that the information given by me in applying for payment is correct. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for services to **Savannah Speech and Hearing Center**.

I authorize **Savannah Speech and Hearing Center** to release to all insurance companies and/or compensation carriers only such diagnostic, therapeutic, and financial information as may be necessary to determine benefits entitled and to process payment claims for health service that will be provided.

The insurance information given is an attempt to collect a debt. Any information obtained will be used for that purpose.

I understand and agree that I am financially responsible for charges not covered by assignment.

Date

Responsible Party or Patient

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Please Read Carefully and Initial

NAME: _____

_____ **CONSENT TO TREAT**

I give consent for myself and/or family member to receive the necessary evaluation and/or treatment by Savannah Speech and Hearing Center.

_____ **RELEASE/REQUEST**

Permission is given to Savannah Speech and Hearing Center to release and/or request information when necessary for the records of the above named individual.

_____ **PAYMENT RESPONSIBILITY**

All professional services rendered are charged to the client. Necessary insurance information will be filed for the client. However, the client is ultimately responsible for payment.

_____ **INSURANCE AUTHORIZATION/ASSIGNMENT**

I allow my insurance company to be billed and I request that payment of authorized benefits be made directly to Savannah Speech and Hearing Center for any services furnished to me by that provider. I authorize the release of any information to my insurance company required in the course of treatment that may be used to determine benefits payable under my insurance plan.

_____ **HEARING AIDS**

My insurance policy does not include a hearing aid benefit. Please do not bill my insurance company for hearing aids.

_____ **CONTACT INFORMATION**

I give my consent to leave messages on my voice mail.

I prefer to be contacted at the following number(s).

- _____ Work _____
- _____ Home _____
- _____ Cell _____
- _____ Other _____

Signature

Date

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AUTHORIZATION FORM Use and Disclosure of Protected Health Information

Client's Name _____ DOB _____

I authorize **Savannah Speech and Hearing Center** to use or disclose the above named client's protected health information.

1. Persons or groups authorized to receive this information:

2. Description of the information to be used or disclosed:

3. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations or other applicable state or federal laws.

4. I understand that I may revoke this authorization in writing at any time except to the extent that the action on this authorization has not already occurred.

5. Unless otherwise revoked, this authorization will expire one year from the date of signature or less than a year as indicated: _____

Client (or Representative) Signature

Date

Name of Personal Representative (Please Print)

Relationship to Client

I have received a copy of the Savannah Speech and Hearing Center's Privacy Practices Notice. _____(INITIALS)

Client records are kept for a period of eight (8) years and then destroyed if there has been no activity within that period of time.