AUDIOLOGY ASSOCIATES OF WESTCHESTER™

550 Mamaroneck Ave. 4th Fl. Suite 407
Harrison, NY 10528

325 NY-100
Somers, NY 10589

Welcome to Audiology Associates of Westchester!

Our mission is to provide you with the best possible hearing healthcare services. It is our goal that every time you come to see us, you are satisfied with your experience and pleased that you chose the Audiology Associates of Westchester for your hearing healthcare needs.

____**Harrison** office at 550 Mamaroneck Avenue, Suite 407 (4th floor). There is parking all around the building and handicap accessible entrance in the back of the building.

_____**Somers** office at 325 NY 100. This is in the Towne Centre located next to the post office. There is parking all throughout the Towne Centre.

Preparing for your appointment:

There are four forms in this packet to complete and bring with you or email ahead of time.

1 - Registration Form 2 - Hearing History 3 - Medications 4 - HIPAA Consent Form

- Prior Hearing Evaluations: If you have copies of prior tests, please bring them with you.
- Insurance Cards: To determine if you have a benefit for hearing tests, hearing devices, or other audiology services, please bring your insurance cards with you.
- Insurance referral if you have an HMO plan that requires one for you to see a Specialist.
- If you are coming in for a hearing device consultation, we recommend you bring a family member or friend, as it is helpful to have someone close to you involved in the hearing care process.

Physician Referral: If you are **required** to obtain a referral by your physician, please bring an electronic or written referral on your appointment date.

Payment Policy: We request payment at the time of service. For hearing devices, a deposit of 50% of the total cost is due when hearing devices are ordered.

Insurance Billing: If we are participating in you plan, we will file a claim to your insurance company according to the benefits outlined in your plan. The benefit quoted to us may not be the actual amount paid. If we are not participating with your plan & you choose to see our providers, payment, in full, is expected at the time of service.

Thank you for scheduling with us. We look forward to seeing you!

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REGISTRATION FORM

Name: _____ Date of Birth: _____
(first) (initial) (last)

Preferred Name: _____ Pronouns: _____

Address: _____ Gender: _____

_____

Phone Number: (home) _____ (cell) _____ (other) _____

Email Address: _____

Marital Status: ( ) single ( ) married ( ) divorced ( ) widowed ( ) domestic partner

---

Occupation: _____ Other Contact Person: _____

Employer: _____ Phone: ( )_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

If retired, former occupation: _____ Relationship to You: ___ spouse ___ partner
___ son ___ caregiver ___ friend
___ daughter other _____
___

Referring physician:_____

Ear, Nose & Throat physician:_____
May we send a copy of your test results to your physician? ____ yes ____ no
(if yes, please provide an address/phone/fax number to your physician)
_____

How did you hear about us? (Choose one or more of the following)

___ From someone else who comes here: Name: _____

___ From my physician _____, M.D

___ Internet Search ___ Google ___ Yelp ___ Facebook ___ Instagram ___ Website

___ Walked or drove by & saw sign ___ Printed ad

___ Received info in mail ___ Retirement Community or Residence _____

___ Insurance Company ___ Community Event, Health Fair, Senior Center

___ Other _____

Do you have medical insurance? ___ yes ___ no

Insurance Co. _____ Policy Number: _____
Name of Insured: _____ Group Number: _____
Insured DOB: _____

I certify that the above information is accurate.

Patient/Representative Signature_____ Date: _____

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HEARING HISTORY QUESTIONNAIRE

Name: _____ Date: _____

What is your primary reason for coming in? _____

Indicate any current or past medical problems with your ears:

___ drainage or ear infection ___ pain in the ear ___ ear surgery (including tubes)
___ perforated eardrum ___ TMJ jaw problems ___ pressure equalizing problem
___ aural fullness ___ ear wax buildup
___ seeing ear, nose & throat specialist for _____

Do you have any of the following?

___ dizziness or balance problems describe: _____
___ tinnitus (ringing / buzzing) describe: _____
___ history of noise exposure work related exposure? ___ yes ___ no
___ family history of hearing loss relatives _____
___ none

What other health condition do you have?

___ arthritis ___ diabetes I or II ___ kidney disease ___ Parkinson's
___ numbness ___ poor dexterity ___ migraines ___ poor memory
___ asthma ___ head injury ___ liver disease ___ stroke / TIA
___ cancer ___ heart disease ___ neurological issues ___ sinus problems
___ smoker ___ other _____
___ none

How is your vision? ___ good ___ fair ___ poor

__wear eyeglasses __wear contacts __glaucoma __macular degeneration __legally blind

Which, if any, of the following situations are difficult for you to hear:

___ soft speech or soft voices ___ phone ___ movie theater ___ music
___ groups of people ___ cell phone ___ lectures ___ family/friends
___ noisy places, restaurants ___ television ___ at the theater ___ none of these
___ religious services ___ radio ___ nature sounds / birds

If you are having difficulty hearing, how have you been managing this? ___ NA

___ I have not done anything, yet ___ I wear hearing devices on the ___right ___ left
___ I have done listening training exercises ___ I have hearing devices, but do not wear them
___ I try to lip read ___ I tried hearing devices, but did not purchase them

Chose or circle a number to indicate how motivated are you to improve your hearing, from 1 to 10 ____.

0 1 2 3 4 5 6 7 8 9 10
Not motivated Somewhat Motivated Very Motivated

If you are considering hearing devices, rank the following items of their importance to you.

1 = most important 2 = important 3 = neutral 4 = not important

___ Sound clarity ___ Best technology ___ Easy to Use ___ Comfortable to wear
___ Cost ___ Reliability ___ Appearance ___ Connection to cell phone

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CURRENT MEDICATIONS

(Prescription drugs, over-the-counter, vitamins & supplements)

Name: ____ DOB: _______________________

Name of Medication	Dosage	Frequency	Route
________________________	___________	__________	___ pill ___ liquid ___ patch ___ injection
________________________	___________	__________	___ pill ___ liquid ___ patch ___ injection
________________________	___________	__________	___ pill ___ liquid ___ patch ___ injection
________________________	___________	__________	___ pill ___ liquid ___ patch ___ injection
________________________	___________	__________	___ pill ___ liquid ___ patch ___ injection
________________________	___________	__________	___ pill ___ liquid ___ patch ___ injection
________________________	___________	__________	___ pill ___ liquid ___ patch ___ injection
________________________	___________	__________	___ pill ___ liquid ___ patch ___ injection
________________________	___________	__________	___ pill ___ liquid ___ patch ___ injection
________________________	___________	__________	___ pill ___ liquid ___ patch ___ injection
________________________	___________	__________	___ pill ___ liquid ___ patch ___ injection
________________________	___________	__________	___ pill ___ liquid ___ patch ___ injection

Patient/Representative
Signature:____________________________________Date:___________________

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HIPAA CONSENT FORM

As required by the Health Insurance Portability and Accountability Act of 1996, Audiology Associates of Westchester may only use your personal health information for the purposes of treatment, payment, or health care operations.

- The specific uses and disclosures we intend to make are described in our Notice of Privacy Practices. You have the right to review the Notice of Privacy Practices prior to signing this Consent Form.
- You may request restrictions on the uses and disclosures described in the Notice of Privacy Practices by describing the requested restrictions in the Restriction Request Section of this form.
- The office is not obligated to accept your proposed restrictions, but the office will give them fair consideration.
- You may revoke this consent at any time by signing the Revocation Section of this form.

I consent to the use or disclosure of my protected health information by the office for the purpose of providing treatment to me, for obtaining payment, or for conducting health care operations. I understand that treatment of me by my health care providers may be conditioned upon my consent.

Patient Name: _____ Date: _____

Signature of patient
or representative: _____

Insurance Authorization and Assignment

I request that payment of authorized Medicare/Other Insurance company benefits made either to me or on my behalf to provider for any services furnished me by that party who accepts assignment/audiologist. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare/Other Insurance company claim. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare/Other Insurance company assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare/Other Insurance companies as the full charge, and the patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/Other Insurance company.