Presbyterian ear Institute

PRESBYTERIAN EAR INSTITUTE
415 CEDAR ST SE
ALBUQUERQUE, NM 87106
(505) 224-7020 OFFICE

Patient Registration (Please Print Clearly) *TODAY'S DATE* _____

Patient Name _____ Birth date _____
Last Name First Name Middle Initial

Mailing Address: _____ Phone ( ) _____

City: _____ State _____ Zip Code _____

Physical Address (if different) _____

Sex ☐ Male ☐ Female SS# _____/_____/_____ Age_____ ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Ethnicity (***Select all that apply***) ☐ Hispanic ☐ Black ☐ White ☐ Native American ☐ Asian ☐ Other

Email: _____ Alternate Phone ( ) _____

Employer_____ Employer Phone ( ) _____

Who referred you? _____ Primary Care Physician _____

In case of emergency who should be notified? _____Phone_____

Person Responsible for Account _____

Parent/Guardian/Personal Representative Information (Please Print)

Name **(Parent 1)** _____ DOB: _____ Name **(Parent 2)** _____ DOB: _____

Relation to Patient_____ Phone ( ) _____

Address if different from above_____ Email_____

City _____ State_____ Zip Code _____

Employer_____ Employer Phone _____ Occupation_____

Primary Insurance (Please Print Clearly)

Insurance Company Name_____ Phone ( ) _____

Member ID# _____ Group # _____

Insured's Name _____DOB_____SS#_____/_____/_____

Secondary Insurance Is Patient covered by Additional Insurance? ☐ *Yes* ☐ *No*

Insurance Company Name_____ Phone ( ) _____

Member ID# _____ Group # _____

Insured's Name _____DOB_____SS#_____

Signature, I consent to treatment and have supplied all information to the best of my knowledge.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Date

☐ **No Changes** Signature:_____ Date: _____

☐ **No Changes** Signature:_____ Date: _____

☐ **No Changes** Signature:_____ Date: _____

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FAX ~ (505) 224-7023

MEDICAL RECORDS RELEASE / REQUEST FORM

THIS FORM ALLOWS PRESBYTERIAN EAR INSTITUTE TO SEND MEDICAL RECORDS TO THE REFERRING DOCTOR, AUDIOLOGIST, AS WELL AS OTHER PROFESSIONALS AS INDICATED BELOW.

PATIENT INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: ____/____/____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

INFORMATION TO BE RELEASED

** PLEASE INDICATE SPECIFIC RECORDS TO BE RELEASED.*

_____

_____

_____

PARTY RELEASING INFORMATION

FACILITY NAME: _____

FAX NUMBER: _____ ADDRESS: _____

AUTHORIZATION

BY SIGNING BELOW, I HEREBY AUTHORIZE THE ABOVE FACILITY TO OBTAIN PERTINENT INFORMATION, INCLUDING MEDICAL, SOCIAL AND EDUCATIONAL AS NEEDED. IN ADDITION, I AUTHORIZE THAT A PHOTO COPY OF THIS AUTHORIZATION BE ACCEPTED WITH THE SAME AUTHENTICITY AS THIS ORIGINAL. ANY PERSON OR AGENCY RECEIVING THIS INFORMATION IS DIRECTED TO TREAT IT AS CONFIDENTIAL. THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME. THE DISCLOSED INFORMATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT. THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE IT WAS SIGNED.

_____ / /

SIGNATURE OF PATIENT, GUARDIAN, OR PERSONAL REPRESENTATIVE — DATE

☐ **No Changes** Signature: _____ Date: _____

☐ **No Changes** Signature: _____ Date: _____

PRESBYTERIAN EAR INSTITUTE
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Welcome to PEI. Our goal is to provide you with quality medical care in a friendly, safe and caring environment. Although we take pride in the quality of our services, we know there is always room for improvement. If you have any suggestions or concerns related to your care of the service you receive, please request to speak with our office manager. PEI is committed to maintaining the very highest standards of ethics and integrity. We are committed to ensuring that all affairs are conducted in accordance with all applicable laws, rules, regulations policies and procedures.

FINANCIAL AGREEMENT

I, the undersigned patient/guardian/parent, assign directly to Presbyterian Ear Institute all benefits otherwise payable to me for services rendered. I also authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronic. I acknowledge that co-pays and deductibles are due at the time of treatment. I accept full financial responsibility for all charges not covered by insurance.

APPOINTMENT NON-COMPLIANCE CONTRACT

PEI understands that not showing and late cancellations for appointments sometimes cannot be helped. As soon as you are aware that you will be unable to keep your appointment, please notify the office immediately. Patients who no show or cancel with less than 24 hours notice of their scheduled appointment will be charged a $25.00 fee for which the patient, not the insurance company, is responsible. This fee must be paid in full before PEI will allow another appointment to be scheduled.

FACILITY AGREEMENT

Presbyterian ear institute (PEI) will make every attempt to make the wait comfortable, but we do insist that clients who are coming to Presbyterian Ear Institute for audiology testing (hearing tests), speech and language evaluation or therapy visits remain in the lobby while waiting for their provider. The provider will come to the lobby to accompany their client(s) to their office. **Guardians of minor clients must remain on Presbyterian Ear Institute property while the patient is being seen. No exceptions will be made.**

All patients/visitors to PEI must sign in at the front desk prior to any appointments.

Presbyterian ear institute (PEI) has several programs including a ***parent infant program***, ***speech and language therapy program***, and ***Presbyterian Ear Institute Oral School***. The school has a playground on site, as well as classrooms and a learning center. Due to insurance liability these areas are for enrolled students of Presbyterian Ear Institute and their families upon staff supervision only.

By signing below it is understood that all the above policies of Presbyterian Ear Institute will be followed.

PATIENT OR GUARDIAN (IF PATIENT IS MINOR)	DATE
PEI RECEPTIONIST	DATE

Presbyterian ear Institute

CONSENT TO EMAIL OR TEXT USAGE FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information to the following Cell Phone number:

Cell Phone Number	( ) –

I authorize to receive email/text messages for appointment reminders and general health reminders/feedback/ information in the Patient Portal to the following Email Address:

_____

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details.

Signature		Name (please print)		Date	

Presbyterian ear Institute

HIPAA PRIVACY POLICY

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY THE STUDENT HEALTH CENTER AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Please note: Our full HIPAA Privacy Policy is available at the front desk of our office and we can also provide our full HIPAA policy handout for your records upon your request. You can also access the full form on our website at peiabq.org/contact.

ACKNOWLEDGEMENT OF RECEIPT:
Federal law requires that we seek your acknowledgment of receipt of this Notice of Privacy Practices. Please sign below.

I acknowledge that I have received this Notice of Privacy Practices with an effective date of July 31, 2008, and that I understand that if I have any questions regarding this Notice, I may contact the Privacy Officer.

Signature: _____ Date: _____

Printed Name: _____

Signature of Parent/Guardian(specify which):

_____ Date: _____

For Office Use Only

Signed Acknowledgment of Receipt received on _____.
Initials _____

Notice of Privacy Practices sent/delivered on _____.
Initials _____

Patient Refused or Failed to Acknowledge Receipt on _____.
Initials _____

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AUDIOLOGY
Adult Case History

Name: _____ DOB: _____ Date: _____

GENERAL

1. What is the primary reason for your appointment today?
   _____
   _____

2. Who referred you to Presbyterian Ear Institute? _____

3. Have you ever had a hearing test? ☐ Yes ☐ No
   Where? _____
   What were the results? _____

4. Do you have any concerns about your hearing? ☐ Yes ☐ No

5. In which ear do you hear the best? ☐ Right ☐ Left ☐ Same in both ears

6. Does anyone in your family have a hearing loss? ☐ Yes ☐ No
   If so who? _____

7. Have you ever been exposed to occupational or recreational noise? ☐ Yes ☐ No
   (Ex: military, music, gun fire)
   If yes, please describe: _____

MEDICAL

8. Have you had earaches or drainage from your ears within the last 90 days? ☐ Yes ☐ No

9. Have you had medical/surgical treatment for your ears? ☐ Yes ☐ No
   If yes, at what age? _____

10. Do you ever have dizziness, balance problems, or falls? ☐ Yes ☐ No

11. Do you experience any tinnitus (for example: ringing, buzzing, or roaring) in your ears? ☐ Yes ☐ No
    If so, which ear? ☐ Right ☐ Left How frequent? _____
    Is it bothersome? ☐ Yes ☐ No

12. Do you have any concerns about your physical or mental development? ☐ Yes ☐ No

13. What is your general health? ☐ Good ☐ Average ☐ Poor

14. Please list any medications (including non-prescriptions) you are currently taking or have taken recently:
    _____
    _____

Adopted in part from ASHA

15. Have you ever had any of the following?

☐ Arthritis	☐ Diabetes Type II	☐ Pacemaker
☐ Allergies	☐ Hepatitis	☐ Parkinson's
☐ Bell's Palsy	☐ High Blood Pressure	☐ Scarlet Fever
☐ Cancer	☐ High Fevers	☐ Seizures
(Type/Treatment:_____)	☐ HIV	☐ Stoke/TIA
☐ Concussion / Skull Fracture	☐ Measles	☐ Tuberculosis
☐ Dementia / Alzheimer's	☐ Meningitis	☐ Vision Problems
☐ Depression / Anxiety	☐ Multiple Sclerosis	☐ Other:_____
☐ Diabetes Type 1	☐ Mumps	

HEARING HISTORY

16. Do you have difficulty hearing/understanding in any of the following activities?

☐ Watching TV	☐ Restaurants	☐ Meetings
☐ Telephone	☐ Movies	☐ Worship Service

17. Do you have trouble hearing a:

☐ Telephone ring	☐ Doorbell	☐ Alarm Clock
☐ Fire/smoke detector	☐ Siren	☐ Baby Cry

18. Have you ever worn a hearing aid? ☐ Yes ☐ No

19. Do you use a hearing aid now? ☐ Yes ☐ No

If yes, how long have you had a hearing aid? _____

On which ear do you use the hearing aid? ☐ Right ☐ Left

Do you wear it regularly? ☐ Yes ☐ No

Do you feel you benefit from it? ☐ Yes ☐ No

Adopted in part from ASHA