Ahlberg Audiology
& Hearing Aid Services
"Your hearing is our priority"

Patient Application - Please Print

Patient Information

Date:_____/_____/_____

Last Name:	First Name:	MI:	Nickname:
Street Address:	City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:	
Email Address:	May we contact you by mail? ☐ Yes ☐ No	Email? ☐ Yes ☐ No	
Birthdate:	Social Security Number:		
Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Retired? ☐ Yes ☐ No	
Primary Care Physician:	Physician's Phone Number:		
How did you hear about Ahlberg Audiology? ☐ Physician ☐ Newspaper ☐ Website ☐ Mailer ☐ Friend ☐ Referral ☐ Other _____			

Employer:		Employer's Phone Number:
Spouse's Name (Parent if under 18):		Phone Number:
Primary Insurance:	Policy Holder's Name (if not patient):	
Secondary Insurance:	Policy Holder's Name (if not patient):	
Emergency Contact:	Relation:	Phone Number:
What problems are you currently experiencing?		

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Insurance Authorization

I authorize Dr. Tiffany Ahlberg, Au.D., CCC-A to release any medical information necessary to my Insurance Company for my primary or referring physician. I authorize Dr. Ahlberg to file on my behalf and to receive payment of medical benefits directly for dependents and myself. I understand I am responsible for any deductibles, co-insurance or amounts for services not covered by my insurance carrier. I realize if the account is past due, I will be responsible for collection cost, attorney fees, and / or legal fees. I have been offered a copy of HIPPA Privacy Policy for this office.

Patient Signature:_____ Date:_____

***** Most insurance does not cover hearing aid related visits. Although a few insurances cover a portion of hearing aids, most do not. Medicare does not cover the cost of hearing aids or hearing related visits. There is an office charge for hearing aid visits when devices were not purchased from Ahlberg Audiology and / or hearing aids not under a service contract or insurance*****

If I choose to give a testimonial for Ahlberg Audiology, I agree this office to use my name or photograph for marketing purposes.

Patient Signature:_____ Date:_____

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CONSENT TO COMPLY WITH THE FEDERAL HIPPA ACT

Patient Consent for Use and Disclosure of Professional Health Information

Patient Name:_____ **Date:**_____

With my consent and signature, Ahlberg Audiology, may use and disclose protected health information about me or my child to:

1. Carry out treatment, payment and healthcare operations (services).
2. Call my home or other designated locations and leave a message on voicemail in references items (i.e., appointments, reminder, insurance items, references to clinical care of laboratory results, etc.) that will assist in the practice of medical care.
3. Mail to my home or other designated addresses any item (i.e., appointments, remainder, insurance items, references to clinical care of laboratory results, etc.) that will assist in the practice of medical care.
4. Send or transmit email to any location provided by me for all of the above similar items and purchases.
5. To use and/or protected health information about me or my child with third parties in my child's care or mine. Such parties may include, but are not limited to, insurance companies, hospitals, specialty physicians and laboratory personnel. I specifically may describe the information (i.e. dates of services, level of detail, origin of information, etc.) subject to disclosure and revoke this permission at a time and date chosen by me. By providing a written statement to the privacy officer of Ahlberg Audiology, I may revoke this permission; however Ahlberg Audiology may decline to further treatment to my child or me. Ahlberg Audiology may also decline further treatment should my restriction on the type of third party information, in the office's opinion, impede medical care of my child or me.

- I have read the right to review the Notes of Privacy Manual of Ahlberg Audiology. Ahlberg Audiology may revise its manual and procedures at any time deemed necessary, and I may request from time to time, in writing, such changes, should these changes directly relate to my care or the care of my child.
- I have the right to request that Ahlberg Audiology restrict how it uses or discloses my or my child's health information. However, as previously states, Ahlberg Audiology is not required to agree with my restrictions. If Ahlberg Audiology accepts my restrictions, Ahlberg is bound by the restriction in the agreement setting forth in the restricted information until providing me, in writing, as cessation, of such agreement.
- I may revoke this entire consent, in writing, at any time, If I do not sign this consent, or revoke this consent, Ahlberg Audiology, in their sole discretion, may decline further treatment for me or my child.

I wish to be contacted in the following manner (check all that apply):

☐ Home Phone ☐ Cell Phone ☐ Text Message ☐ Email ☐ Work Phone
☐ Message on answering machine ☐ Message left with person who answers phone

You may disclose PHI (Protected Health Information) to the person(s) listed below:

_____ _____

_____ _____

_____ _____
Patient Signature Date

The privacy rule requires healthcare providers to take responsible steps to limit the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to the use or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided on the "Accounting of Disclosures" if completed properly, will by constituted an adequate record..Note***Uses and disclosures of information may be permitted without prior consent in the case of an emergency.***

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Medical History

Check all that apply

- ☐ Hearing Loss-Gradual
- ☐ Hearing Loss-Sudden
- ☐ Worn Hearing Aids
- ☐ Family History of Hearing Loss
- ☐ Past Ear Surgery
- ☐ Taking Blood Thinners
- ☐ History of Depression
- ☐ History of Cancer
- ☐ Other_____

- ☐ Tinnitus
- ☐ Dizziness
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Stroke
- ☐ Fallen in the past 6 months
- ☐ Fallen in the past year
- ☐ Other_____

- ☐ Chronic Ear Pain/Drainage
- ☐ Visual Problems
- ☐ Past Head Injury
- ☐ Meningitis
- ☐ Measles
- ☐ Noise Exposure
- ☐ Current Tobacco User
- ☐ Other_____
- ☐ Other_____

Please list all other medications you are currently taking:
(If you have your list, we will be happy to make a copy of it for our records)

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Quick Patient Profile

1. What brought you into the office today?

2. Please select the following boxes that apply to your current hearing abilities in various environments.
   Select one: ☐ With Hearing Aids ☐ Without Hearing Aids

Listening Environments	How well do you currently hear in this environment?	How frequently are you in this environment?	Which 3 environments do you struggle hearing the most?
One-to-one conversations	☐ Well ☐ Fair ☐ Poor	☐ Often ☐ Sometimes ☐ Rarely	☐
Quiet Room (1 to 2 people)	☐ Well ☐ Fair ☐ Poor	☐ Often ☐ Sometimes ☐ Rarely	☐
Small Groups (4 to 6 people)	☐ Well ☐ Fair ☐ Poor	☐ Often ☐ Sometimes ☐ Rarely	☐
Large Social Gatherings	☐ Well ☐ Fair ☐ Poor	☐ Often ☐ Sometimes ☐ Rarely	☐
At the Workplace	☐ Well ☐ Fair ☐ Poor	☐ Often ☐ Sometimes ☐ Rarely	☐
Watching Television	☐ Well ☐ Fair ☐ Poor	☐ Often ☐ Sometimes ☐ Rarely	☐
During Religious Services	☐ Well ☐ Fair ☐ Poor	☐ Often ☐ Sometimes ☐ Rarely	☐
Meetings/ Lectures	☐ Well ☐ Fair ☐ Poor	☐ Often ☐ Sometimes ☐ Rarely	☐
In the Car	☐ Well ☐ Fair ☐ Poor	☐ Often ☐ Sometimes ☐ Rarely	☐
Outdoors	☐ Well ☐ Fair ☐ Poor	☐ Often ☐ Sometimes ☐ Rarely	☐
On the Telephone	☐ Well ☐ Fair ☐ Poor	☐ Often ☐ Sometimes ☐ Rarely	☐

3. What is your experience with hearing aids? Check all that apply.
   - ☐ I have never used or visited a Hearing Healthcare Professional to inquire about hearing aids.
   - ☐ I have been to another Hearing Healthcare Professional to gather information regarding my hearing difficulties but have not tried or purchased.
   - ☐ I have tried hearing aids but only wear occasionally or not at all.
   - ☐ I have hearing aids but only wear occasionally or not at all.
   - ☐ I have a hearing aid and wear it regularly on the ☐ right ear, ☐ left ear.

4. Please rank the following in terms of their importance (1 to 4, with 1 being the most important.
   ☐ Overall Sound Quality ☐ Reliability ☐ Style/Appearance ☐ Cost

5. How motivated are you regarding doing something about your hearing loss?
   ☐ Not Motivated ☐ Somewhat Motivated ☐ Very Motivated ☐ Extremely Motivated

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