Dear Patient:

We appreciate the opportunity to have served you. We value you as a member of our family of patients here at El Dorado Audiology. Our commitment is to provide the best understanding of your hearing healthcare needs and the most extensive personalized service.

As part of your continued hearing healthcare, you have been scheduled for an evaluation to update your patient file with a current hearing evaluation.

Please complete the enclosed forms, and bring them with you to your appointment. This information is important for us to determine how we can continue to provide the best service. Please plan for approximately 1 hour for your evaluation appointment. We request that you bring someone close to you — or someone with whom you speak on a regular basis — to attend the appointment with you. This is for your benefit, as well as contributing to the evaluation by your Hearing Healthcare Professional

When you come in for your hearing evaluation, you can expect us to:

1. Review your health history with you and discuss any changes since becoming a patient of El Dorado Audiology;
2. Perform a complete hearing evaluation; and
3. Explain your current test results in detail.

If you have any questions prior to your appointment, please call us at 885-0234. We are looking forward to seeing you.

Sincerely,

Carolyn Jaret

Carolyn Jaret, MS, CCC-A
Owner, El Dorado Audiology

EL DORADO AUDIOLOGY HEARING QUESTIONNAIRE

Our focus is your Hearing Health and to provide optimum care. Pease complete this questionnaire. The information is kept confidential and is part of your permanent file.

Thank you for placing your trust in us for all of your hearing needs.

Patient Information

Name: ______________________________ Date of Birth: ______________
Last First Initial

Mailing Address: ____
Address City State Zip

Telephone: ____________ ________________ ______________
Home Work Ext. Cell

Email: ______________________ May we contact you by email? YES NO

Marital Status: ______________________ Spouse's Name: ______________

Occupation: PAST / PRESENT (Please circle one)

Are you a winter resident? YES NO If YES, name of park/community: ______________

Approximate dates you are here in Tucson From: __________ To: ____________

Summer Address: ____

Emergency Contact: ______________ Phone: __________ Relationship: ________

Primary Care Physician Information

Name: ______________________________ Phone: ______________

Address: ____

Do you want a copy of your report mailed to your physician? YES NO

I authorize a copy of my records to be sent to my physician ____________________ __________
Patient Signature Date

Insurance Information

Primary Insurance Company: ____________ Identification # ________ Group # ________

Policy Holder Name: ____________ Relationship to Patient: ______________

Secondary Insurance Company: ____________ Identification # ________ Group # ________

Policy Holder Name: ____________ Relationship to Patient: ______________

MEDICAL/AUDIOLOGIC HISTORY

SPECIALISTS IN HEARING
EL DORADO AUDIOLOGY INC
EXPERTS IN LISTENING

Why have you decided to update your hearing test at this time?

- ☐ I feel my hearing/understanding has declined since first wearing hearing devices.
- ☐ Family/friends have suggested I have my hearing rechecked.
- ☐ Other reason/explain: ____

How well do you hear with your current devices? ____

How often do you wear your current devices? ____

Which ear do you hear worse? (please circle one) LEFT RIGHT BOTH

Are your current devices comfortable? (please circle one) YES NO

If no, please explain:

How long have you been wearing your current set of hearing devices? ____________

Have you had ear surgery since becoming a patient of El Dorado Audiology? YES NO

If yes, when? ______________________ Which ear? L R Procedure? ______________________

Do you have noises or ringing in your ears? YES NO

If yes, circle: RIGHT LEFT BOTH

How often? CONSTANTLY FREQUENTLY OCCASIONALLY

Have you had any trauma to the head since becoming a patient of El Dorado Audiology? YES NO

If yes, explain: ____

When wearing your devices, do people seem like they still mumble? YES NO

When wearing your devices, do you have difficulty hearing/understanding when visiting friends, relatives or neighbors? YES NO

When wearing your devices, do you have difficulty hearing/understanding when attending Religious Services? YES NO

When wearing your devices, do you have difficulty hearing/understanding when listening to TV or radio? YES NO

When wearing your devices, do you have difficulty hearing/understanding in a restaurant? YES NO

When wearing your devices, do you have difficulty hearing/understanding women or children? YES NO

When wearing your devices, do you have difficulty hearing/understanding on the telephone? YES NO

MEDICAL/AUDIOLOGIC HISTORY

Have you had or currently experiencing any of the following:

- ☐ High blood pressure
- ☐ Heart disease
- ☐ Arthritis
- ☐ Diabetes
- ☐ Cancer
- ☐ Stroke
- ☐ Meningitis
- ☐ Mumps
- ☐ Kidney disease
- ☐ Measles

Please list any prescription medications that you are currently taking:

____

____

____

____

____

____

Have you ever taken:

- ☐ Chemotherapy
- ☐ Streptomycin
- ☐ Gentomycin
- ☐ Vancomycin
- ☐ Lasix
- ☐ Large doses of aspirin

Have you had any drainage from your ears in the last 90 days? YES NO

Have you noticed a sudden change in your hearing in one or both ears in the last 90 days? YES NO

Have you experienced any earaches recently? YES NO

Do you suffer from seasonal allergies? YES NO

Do your ear canals itch? YES NO

ASSESSMENT OF PRIORITIES FOR OPTIMUM HEARING

Our goal is to maximize your ability to hear and understand speech so that you can more easily communicate with others. In order to reach this goal, it is important that we understand your communication needs, your personal preferences, and your expectations. By having a better understanding, we can utilize our expertise to recommend the hearing devices that are most appropriate for you. By working together we will find the best solution.

Please list the top three situations where you would most like to hear better. Be as specific as possible.

____

____

____

What **do** you like about your current hearing devices?

____

____

____

What **don't you** like about your current hearing devices?

____

____

____

If there is one thing you would like to change about your current hearing devices what would that be?

____

____

____

Patient's Signature: ____________________________________ **Date:** ______________________

Thank You for choosing El Dorado Audiology, the Practice of Choice for Hearing Healthcare

NOTICE OF PRIVACY PRACTICES FOR EL DORADO AUDIOLOGY, INC.

PURPOSE:

This Privacy Notice is required by the Privacy Regulations stemming from the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This Privacy Notice explains to you, a patient of this practice, how your medical information may be used and disclosed, and how you can get access to your medical information.

1. OUR COMMITMENT TO YOU REGARDING MEDICAL INFORMATION

This practice is determined to protect the privacy of your medical information. In order to provide you with quality care and service, as well as comply with the law, we must create a medical record for you and document the care and services you receive at this practice. Federal law requires us to ensure the confidentiality of your medical record. This notice will explain to you which circumstances require us to use or disclose your medical information. We also describe your rights, as well as our obligations, regarding the use and disclosure of medical information.

2. WHAT THE LAW REQUIRES US TO DO

The Federal Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the law permits the changes.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of change to privacy practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

Following is a description of the different circumstances that may require this practice to use or disclose your medical information. For any of these circumstances, you can submit a written request restricting our use or disclosure of your medical information for treatment, payment, or healthcare operations. You may also request (in writing) that we only disclose your medical information to certain individuals responsible for your care or the payment for your care. Legally we are not required to agree to your request. If we do agree to honor the written request, then we must abide by our agreement unless in those situations required by law, in emergencies, or when information is necessary to treat you. If you wish to revoke any previously written request, you may do so in writing.

For treatment:

We may use your health information to provide you with medical treatment or services, such as sharing medical data with another provider, making referrals, and placing lab and prescription orders. We may disclose your health information to those people who are responsible for your care, for instance, your doctors, nurses, technicians, medical students, or any other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For payment:

We may use and disclose your health information for payment purposes. For instance, we may need to give your health insurance plan information about a treatment you received at our practice when filing a claim, so that your health plan can either pay us or reimburse you for your payment. We may also tell your health plan about a treatment you are going to receive to get approval or to determine if your plan will pay for the treatment.

For health care operations:

We may use and disclose your health information for our healthcare operations. This includes quality assurance, employee performance evaluations, conducting training programs, and getting the accreditation, licensure, and credentialing.

Additional uses and disclosures:

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

a. Medical information to notify or help notify:

- A family member
- Your personal representative
- Another person responsible for your care

We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

b. Disaster Relief:

We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

c. Research in Limited Circumstances:

Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information

d. Funeral Director, Coroner, Medical Examiner:

To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

e. Specialized Military Personnel Functions:

Your medical information may be disclosed if you are military personnel, either active status or a veteran, and if required by the appropriate authorities.

f. Public Health Activities:

Your medical information may be disclosed if required to do so by a public health or law enforcement official whose job is to prevent or control disease, injury or disability. Your medical information may also be disclosed to a person from the Food and Drug Administration for the purposes of reporting adverse effects stemming from product defects or problems, to enable product recalls, repairs or replacements, or to conduct activities required by the Food and Drug Administration.

g. Personal Health and Safety:

Your medical information may be disclosed when necessary to prevent a serious threat to your health and safety or the health and safety of another individual or the public. The information will be disclosed only to a person or organization able to prevent the threat.

h. Workers Compensation:

Your medical information may be disclosed when necessary to comply with the laws for the Workers Compensation Program.

i. Public Health Oversight Activities:

Your medical information may be disclosed to public health authorities and health oversight agencies that are authorized by law to gather health information (e.g. audits, licensure, disciplinary actions, administrative and criminal investigations, etc.)

j. Law Enforcement:

Your health information may be disclosed in response to a court or administrative order in a lawsuit or similar proceeding.

4. YOUR INDIVIDUAL RIGHTS

You Have the Right to:

1. Look at or get copies of your medical records on file. You have the right to receive a copy of the Privacy Notice. To receive a copy, please notify the receptionist.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions. Request that we place additional restrictions on our use or disclosure of your medical information.
3. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or a different location must be made in writing to the contact person listed at the end of this notice.
5. Ask to change your health information if you think it is incomplete or inaccurate. The request must be made in writing to the contact person listed at the end of this notice. If, however, the physician or audiologist finds that the patient’s health information is complete and accurate, he/she can refuse to make the requested changes.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

5. QUESTIONS AND COMPLAINTS

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Carolyn Jaret, MS, CCC-A at 520 885-0234

If you think that we may have violated your privacy rights, contact the person named above. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

6. ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name ____

Signature ____

Date ____

The Privacy Rule portion of the HIPAA regulations requires our practice to submit a copy of the Privacy Notice to each patient, both existing and new. If the patient refuses to sign the notice, this practice is not obligated to treat the patient.