



The Hearing Health Center of Houston

3275 W. Alabama Street
Houston, TX 77098

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(F) 713-942-8202
www.hearinghealthhouston.com
info@hearinghealthhouston.com

PATIENT INFORMATION FORM

Chart #: _____

Date: _____

Personal Information

Full Name: _____ Birth Date: _____
Last First M.I. mm/dd/yyyy

Address: _____
Street Address Apartment/Unit # City State ZIP Code

Primary Phone: _____ Alternate Phone: _____

Email: _____ Occupational Status: _____

Primary Care Physician: _____
Name & Affiliation Address/Phone

Marital Status (Please Circle): Married Single Long-term commitment Widowed Divorced

Spouse's Name: _____
Last First M.I.

Name of Responsible Party: _____
If patient is <18 years Last First M.I.

Emergency Contact Information

Full Name: _____
Last First

Primary Phone: _____ Relationship: _____

Insurance Information

Primary: _____ Secondary: _____

Policy Holder: _____ Birth Date: _____
If not self

Referral Information

- Direct Mail
- Radio
- Phonebook
- Outdoor Sign
- DARS: _____
- Event: _____
- Insurance: _____
- Company: _____
- Physician: _____
- Friend: _____

Online Sources

- Hearinghealthhouston.com
- Google Ad
- Yelp
- Google+
- Facebook
- Google Maps
- LinkedIN
- Bing
- BBB
- Pinterest
- Healthyhearing.com
- Healthgrades.com
- Hearingtracker.com



Office Policies

No Show/Cancellation Policy

When we schedule an appointment, we set aside time for you to receive the highest quality care. If you need to cancel an appointment, please contact our office no later than the day before your scheduled appointment.

If you fail to present for a scheduled appointment, without contacting the office at least 24 hours prior to the appointment, you will be considered a "No Show" and will be charged a fee of \$35.00. This fee is charged to you, not your insurance company, and it is due at the time of your next appointment.

Payment

Payment is due in full when services are rendered, unless other arrangements have been made. There will be a \$25.00 fee for returned checks.

Responsible Party Statement

I will pay in full The Hearing Health Center of Houston the appropriate co-pay and/or deductible remaining from Medicare or private insurance in the event I have no secondary coverage policy. In the event Medicare Part B and/or Medicaid eligibility cannot be determined, I will pay the account balance in full.

Privacy Policy/HIPAA

I have received and reviewed a copy of the Health Insurance Portability & Accountability Act (HIPAA)/Confidentiality Notice, and it has been explained to me.

Authorization for the Release of Information

This signed document grants The Hearing Health Center of Houston, a division of SpeechPath Associates, Inc., authorization for the release of all information required for services in order to process insurance claims on my behalf. I hereby assign and transfer to The Hearing Health Center of Houston all rights, title and interest benefits payable from all my insurance carriers. I/We understand that we are responsible for the payment of the charges for this appointment.

I authorize my insurance carrier (Medicare, Medicaid, or private insurance) to reimburse The Hearing Health Center of Houston for all benefits due by reason of services rendered. In the event the insurance carrier reimburses me in error, payment will be directly forwarded to The Hearing Health Center of Houston.

I authorize the release of my medical records **to and from** the following individuals or entities. I may revoke this release in writing at any time; however, this consent for release will only be in force for 1 year unless I indicate below that I wish to extend it. This release allows communication of professionals and sharing of relevant records/information between the following institutions:

Name: _____ Time Period for Release: _____

Name: _____ Time Period for Release: _____

Name: _____ Time Period for Release: _____

_____ I authorize the release of my hearing health records to my primary care physician *(listed on page 1)*

_____ I authorize the release of my child's hearing health records to his/her school and authorize subsequent communication

Name of School/Teacher: _____

Address: _____

Acknowledgement of Office Policies

I have read all of the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge and hereby give The Hearing Health Center of Houston permission to treat my concerns. I have read and understand the office policies of The Hearing Health Center of Houston. I agree to be responsible for all the fees as outlined and the cancellation penalties as explained. *A photocopy of this assignment shall be considered as effective and valid as the original.*

Patient Signature Printed Name Date

Signature of parent or guardian Printed Name Date

Privacy Policy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR MEDICAL HEALTH AND HEARING LOSS MAY BE USED AND DISCLOSED. IT DESCRIBES HOW YOU GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

General Information

Information about your treatment and care, including payment for care, is protected by two federal laws: The Health Insurance Portability and Accountability Act of 1996¹ (HIPAA) and the Confidentiality Law². Under these laws we may not acknowledge or disclose any information about your hearing loss or treatment and any other protected information except as permitted by the federal laws reference below.

We must obtain your written consent before we can disclose information about you for payment purposes. For example, we must obtain your written consent before we can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before we can share information about your treatments to anyone. However, federal law permits the program to disclose the information in the following circumstances without your written permission.

1. To staff members for the purpose of providing treatment and maintaining the clinical record;
2. Pursuant to an agreement with a business associate (e.g. Hearing aid manufacturers, record storage services, billing services);
3. For research, audit or evaluations (e.g. state licensing review, accreditation);
4. To report a crime committed on the premises or against our staff;
5. To medical personnel in a medical emergency;
6. To appropriate authorities to report suspected abuse or neglect;
7. As allowed by court order.

Before we can use or disclose any information about your health in a manner which is not described above, we must first obtain your specific written consent allowing use to make the disclosure. Any such written consent may be revoked by you in writing.

¹42 U.S.C 130d et. Seg., 45 C.F.R. Parts 160 & 164 ²42 U.S.C. 290dd-2, 42 C.F.R. Part 2

Your Rights:

- Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health and treatment information. We are not required to agree to any restrictions that you request, but if we do agree with them, we are bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.
- You have the right to request that we communicate with you by alternative means or at an alternative location (e.g. another address). We will accommodate such requests that are reasonable and will not request an explanation from you.
- Under HIPAA you also have the right to inspect and copy your own health and treatment information maintained by The Hearing Health Center of Houston, except to the extent that the information is for use in civil, criminal or administrative proceeding or in other limited circumstances.
- Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in our records, and to request and receive an accounting of disclosures of your health related information made by us during the six (6) years prior to your request.
- If your request for any of the above is denied, you have the right to request a review of the denial by the Director of The Hearing Health Center of Houston.
- To make any of the above requests, you must fill out the appropriate form that will be provided to you.
- You also have the right to receive a paper copy of this notice.

The Use of Your Information

In order to provide you with the best care, we will use your health and treatment information in the following ways:

- Communication among staff for the purpose of treatment, treatment planning, progress reporting and review, staff supervision, incident reporting, billing operations, medical record maintenance, and other treatment related processes.
- Communication with Business Associates such as clinical laboratories (earmold impressions), hearing aid manufacturers, and companies that provide data backup services and data security.
- Reporting data to the Texas Department of Health Newborn Hearing Screening Program

Our Responsibilities

We are required by federal law to maintain the privacy of your health information and to provide you notice of our legal duties and privacy practices with respect to your health information. We are required by law to abide by the terms of this notice. We reserve the right to change the terms of this notice and to make new notice provisions effective for all protected health information we maintain. We will provide current patients with an updated notice, and we will provide affected former patients with new notices when substantive changes are made in the notice.

Complaints and Reporting Violations

Patients have the right to make a complaint about the Confidentiality and Privacy of their Health Information. You may complete a Privacy Complaint and submit the form to the privacy Officer here at The Hearing Health Center of Houston, or directly to the Texas Department of Health Speech Pathology and Audiology Board.

You will not be retaliated against for filing such a complaint.

Sunita Kavrie, Ph.D., Privacy Officer
The Hearing Health Center of Houston
3275 West Alabama
Houston, TX 77098

Office for Civil Rights

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D. C. 20201
202-619-0257