pacificaudiologyclinic

5200 S Macadam Avenue, Suite 200 | Portland, Oregon 97239
Phone # (503) 719-4208, Fax # (503) 719-4209
www.pacoregon.com

Patient Information

Name: _____ Date of Birth: _____
Sex: Male ☐ Female ☐
Address: _____ Apt#: _____
City: _____ State: _____ Zip: _____
Primary Phone: _____ (☐ cell / ☐ work / ☐ home) Cell Phone Carrier: _____
Secondary Phone: _____ (☐ cell / ☐ work / ☐ home)
Employer: _____ Occupation: _____
Work Address: _____
Social Security #: _____ Email Address: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered

☐ Spouse ☐ Partner ☐ Parent ☐ Guardian Information (Check One)

Name of spouse, parent or guardian: _____
Street Address: _____ Apt #: _____ City: _____ State: _____ ZIP: _____
Mailing Address (if different): _____
Home Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____
Work Address: _____
City/State/Zip _____ Date of Birth: _____
Social Security #: _____ Driver's License #: _____

Insurance Holders' Information

Primary Insurance Co: _____ Phone #: _____
Name of Insured: _____ Date of Birth: _____
Home Phone: _____ Work Phone: _____
SS or ID #: _____ Group #: _____ Co-Pay Amount $ _____
Primary Care Physician: _____
Primary Insurance Co: _____ Phone #: _____
Name of Insured: _____ Date of Birth: _____
Home Address: _____ Home Phone: _____
SS or ID #: _____ Group #: _____

PLEASE PROVIDE YOUR INSURANCE CARD TO PHOTOCOPY

Other Important Information

Person to contact in an emergency (someone not living with you): _____
Relationship to you: _____ Their phone #: _____
How did you hear about our doctors? ☐ Phone Book ☐ Referred by Friend or Family Member
☐ Referred by Physician: _____ ☐ Previous Patient: _____
☐ Other (please specify): _____

I authorize Pacific Audiology Clinic or my insurance company to release any information required for processing my insurance claim. I also authorize my insurance benefits to be paid directly to the doctor. I understand that direct billing of insurance companies is done as a courtesy by Pacific Audiology Clinic, LLC and that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees and acknowledges that their social security number may be used in collection efforts. I authorize Pacific Audiology Clinic to provide me with reasonable and proper medical care by today's standards.

Signature _____ Date _____

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5200 S Macadam Ave, Suite 200 | Portland, OR 97239 | **(503) 719-4208**
3502 NE Broadway | Portland, OR 97232 | **(503) 284-1906**
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Billing Policies

By initialing the lines below, I hereby acknowledge and consent to:

_____ **Payment is required at the time of service**. If your insurance requires a co-pay, payment will be due at the time of your appointment. We accept personal checks, cash, Visa and Mastercard. There will be a fee of $25.00 for any returned checks.

_____ **We will bill your insurance carrier; however, we do not accept responsibility for ensuring preferred provider status with your insurance company.** You will be billed for unpaid balances after your insurance processes. The office does not accept responsibility for collecting your insurance claim or for negotiating a settlement of a disputed claim. You are responsible for payment of your account and any unpaid insurance claims. .

_____ **Upon purchase of a hearing aid, payment is required in full.** We will then bill your insurance and issue you a refund if one is owed. If payment arrangements must be made, please discuss this with your provider. We work with Wells Fargo and Care Credit for financing options. Please discuss this with your provider for more details on plans we offer. There is a $500 minimum charge to utilize these financing options.

_____ **Client balances that are 60+ days past due will be assessed a $10 per month service charge.** If payment arrangements must be made, please contact our office. Accounts carried over 90 days without payment may be turned over to a collection agency. In that event, the contingency fee assessed will be added to the principal and service charges due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe. If your account is turned over to a collection agency, it may affect your credit rating. In most cases, the only information released to a collection agency about a treatment would be the patient's name, basic contact information, the nature of the services provided, and the amount due.

_____ **We require a 24-hour notice of cancellation. If a 24-hour notice is not given, a late cancellation or no-show charge of $100 may be assessed.** Insurance companies will not be billed for this fee; it is the patient's responsibility. If you need to cancel your appointment during non-business hours, please leave a message on our voicemail. In case of illness, please contact our office as soon as possible to re-schedule your appointment.

Your signature below indicates your understanding of the information provided above. If you wish, our office will provide you with a copy of this policy.

Signature _____ Date _____

IF WE ARE BILLING YOUR INSURANCE, PLEASE READ AND SIGN BELOW

I authorize Pacific Audiology Clinic or my insurance company to release any information required for processing my insurance claim. I also authorize my insurance benefits to be paid directly to the provider. I understand that billing of insurance companies is done as a courtesy by Pacific Audiology Clinic, LLC and that I am financially responsible for all charges.

Signature _____ Date _____

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Acknowledgment and Consent

(For HIPAA Compliance Purposes)

I understand that Pacific Audiology Clinic (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my audiologists' efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: _____ Date: _____
(Patient)

-OR-

By: _____ Date: _____
(Patient representative)

Description of Representative's Authority: _____

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Children's Case History Questionnaire

Today's Date: _____

Child's Name: _____ Age: _____ Birth Date: _____

School attending (if any) _____ Grade: _____

Primary Care Physician: _____ Referred By: _____

Name of Person Completing this Form: _____

Relationship to Patient: _____

Main Reason for Today's Visit:

Passed Newborn Hearing Screening:

- ☐ Right
- ☐ Left
- ☐ Both Ears
- ☐ Not Tested
- ☐ Unknown

Birth Hospital or other birth location: _____

Previous Hearing Tests? (Where? Results?)

Mother's Prenatal-Birth – Postnatal History for this child:

Length of Pregnancy: _____

Please check all that apply:

- ☐ Complications during the child's prenatal development or delivery.
- ☐ Drug/Alcohol use (specify) _____.
- ☐ Baby was born early or late. How many weeks? _____ Early ☐ / Late ☐
- ☐ Baby was cared for in a special care nursery (NICU).
- ☐ Baby received oxygen or ventilation after deliver.
- ☐ Low Birth weight (below 3.3 pounds)
- ☐ Mcconium stain or aspiration.
- ☐ Blood incompatibility

Medical History:

Check any of the following conditions that the baby/child has experienced:

- ☐ Jaundice
- ☐ Blood transfusion
- ☐ Photo light therapy How many days?
- ☐ In-utero infection such as:
  - ☐ CMV ☐ Herpes ☐ Simplex ☐ Toxoplasmosis ☐ Rubella
  - Please specify: _____
- ☐ Exposed to drugs/alcohol
- ☐ Breathing difficulties
- ☐ Seizures
- ☐ Heart Problems
- ☐ Failure to Thrive
- ☐ High Fever
- ☐ Head Trauma
- ☐ Bacterial Meningitis
- ☐ Cerebral Palsy
- ☐ Problems with head, neck, ear or ear canal
- ☐ Cleft Palate
- ☐ History of ear infections
- ☐ ADHD
- ☐ Sensory Integration Dysfunction
- ☐ Autism
- ☐ Neurodegenerative Disorders
- ☐ Developmental Delay Please specify: _____
- ☐ Genetic Syndrome Please specify: _____
- ☐ Metabolic Disorder Please specify: _____
- ☐ Ear Surgery Please specify: _____

Other Information:

Yes ☐ No ☐ Family History of hearing loss (Who?) _____

Yes ☐ No ☐ Family member diagnosed with a learning disorder?
Please specify: _____

Yes ☐ No ☐ Did/Does the baby startle to loud noises?

Yes ☐ No ☐ Does your child turn to sound?

Yes ☐ No ☐ Did/Does the baby quiet to voices or music?

Yes ☐ No ☐ Did/Does your baby babble using consonants such as “bababa”?

Yes ☐ No ☐ Is your child involved with early intervention? If yes, through what program?

_____

Yes ☐ No ☐ Did/Does the child require articulation and or language therapy?

How well can the child be understood? _____

Any speech, language or educational concerns? Describe

Is there any other information that you feel would be useful for us to know?