pacificaudiologyclinic

3502 NE Broadway | Portland, OR 97232
Phone # (503) 284-1906, Fax # (503) 546-0894
www.pacoregon.com

Patient Information

Name: _____ Date of Birth: _____
Gender: ☐ Male ☐ Female ☐ Other Pronouns: _____
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: _____
Primary Care Physician _____ Phone Number: _____
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 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**
www.pacoregon.com

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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Name _____ _____ _____ Date of Birth _____
(Last) (First) (Initial) (M/D/Y)

Occupation (past/present) _____ Primary Care Doctor _____

How did you hear about us? _____ Did you see our website? _____

Home phone _____ Cell phone _____ Work phone _____

Name of spouse or partner _____

Audiologic History

Describe your hearing problems

_____

How long have you noticed a hearing problem _____

What do you believe caused your hearing problem

_____

	YES	NO
Will this be the first time you've had a hearing test?	☐	☐
If no, what year were you last tested _____		
Have you ever had ear surgery?	☐	☐
If yes, when? _____ which ear? _____ type of surgery? _____		
In which ear do you hear better? ☐ left ☐ right ☐ same		
Do you have noises or ringing in your ear(s)?	☐	☐
If yes, sounds like _____ in ☐ right ear ☐ left ear ☐ both ears		
Is the ringing/sound in your ears: ☐ constant ☐ intermittent		
Did you have chronic ear infections as a child or adult?	☐	☐
Do you have drainage from your ears?	☐	☐
If yes, when did it start? _____		
Do you have pain in your ears?	☐	☐
If yes, when did it start? _____		
Do you have a family history of hearing loss?	☐	☐
If yes, who? _____ Were they BORN with a hearing loss? _____		
Have you been exposed to a lot of noise in your life?	☐	☐
If yes, what type? _____		

(see next page)

	YES	NO
Have you ever had a skull fracture/temporal bone fracture?	☐	☐
Do you feel fullness or pressure in your ears?	☐	☐
If yes, which ear? _____ How often? _____		
Do you have dizziness or vertigo?	☐	☐
If so, last episode? _____ How long did it last _____		
Do your ear canals itch?	☐	☐
Do you have sinus or allergy problems?	☐	☐
Are you currently smoking cigarettes?	☐	☐
Packs/day _____ Duration of use _____		

List any medications that you take (please include amount and dosage):

Questionnaire about your hearing

Our concern is your hearing and to better help you we ask that you fill out this questionnaire to describe in what ways your hearing affects you. This information is kept confidential and is made a part of your permanent file. Thank you for placing your trust in us for all your hearing needs. Please complete the front and back side and return to the front desk.

	YES	NO
Do you have difficulty hearing when someone speaks in a whisper?	☐	☐
Do you feel fullness or pressure in your ears?	☐	☐
If yes, which ear? _____ How often? _____		
Does a hearing problem cause you difficulty when visiting friends or relatives?	☐	☐
Does a hearing problem cause you to attend social gatherings less often than you would like?	☐	☐
Does a hearing problem cause you difficulty when listening to TV or radio?	☐	☐
Do you have difficulty hearing women or children?	☐	☐
Does a hearing problem cause you difficulty when in a restaurant with friends or relatives?	☐	☐
Do you feel embarrassed, frustrated and/or angry about your hearing problem?	☐	☐
Does your problem affect your family or relationships?	☐	☐
Do you have difficulty hearing on the telephone?	☐	☐
If yes, which ear do you use on the telephone? (check one) ☐ right ☐ left		
Do you wear hearing aids?	☐	☐
If yes, check one: ☐ left only ☐ right only ☐ both ears		

What year did you buy your hearing aids? _____

(see next page)

	YES	NO
Approximately how many hours a day do you wear them? _____		
Are you currently satisfied with your hearing aids?	☐	☐
Do you have any problems with your hearing aids?	☐	☐

If yes, explain: _____

Why have you decided to have your hearing tested at this time?

- ☐ I feel my hearing is poor and may need to be aided.
- ☐ Family/friends have suggested I have my hearing checked.
- ☐ Other reason/explain: _____

Assessment of Priorities relating to your hearing

If you have a preference for hearing aid technology and/or style, check the appropriate boxes below.

Hearing Aid Technology

- ☐ Advanced Digital Instruments
- ☐ Programmable Instruments
- ☐ Basic Instruments
- ☐ No Preference

Hearing Aid Style

- ☐ Completely-In-the-Canal
- ☐ Canal
- ☐ In-The-Ear
- ☐ Behind-The-Ear

Indicate your ability to hear (Hearing Quality) in the following listening situations and rate the importance of that listening situation to you. Check the appropriate number based on your experiences.

Listening Situation	Hearing Quality					Importance to You		
	POOR				NORMAL	NOT	SOMEWHAT	VERY
QUIET (one on one conversation)	☐1	☐2	☐3	☐4	☐5	☐1	☐2	☐3
TELEVISION	☐1	☐2	☐3	☐4	☐5	☐1	☐2	☐3
RESTAURANTS	☐1	☐2	☐3	☐4	☐5	☐1	☐2	☐3
CHURCH	☐1	☐2	☐3	☐4	☐5	☐1	☐2	☐3
MEETING/GROUPS	☐1	☐2	☐3	☐4	☐5	☐1	☐2	☐3
WORK PLACE	☐1	☐2	☐3	☐4	☐5	☐1	☐2	☐3
TELEPHONE	☐1	☐2	☐3	☐4	☐5	☐1	☐2	☐3
CAR	☐1	☐2	☐3	☐4	☐5	☐1	☐2	☐3
MALE VOICE	☐1	☐2	☐3	☐4	☐5	☐1	☐2	☐3
FEMALE VOICE	☐1	☐2	☐3	☐4	☐5	☐1	☐2	☐3
CHILD'S VOICE	☐1	☐2	☐3	☐4	☐5	☐1	☐2	☐3
OTHER (please explain below)	☐1	☐2	☐3	☐4	☐5	☐1	☐2	☐3

Following you will find a list of important factors to consider when purchasing a hearing instrument. Please rate them in order of importance from 1 to 6 by placing the number 1 next to the most important factor, the number 2 next to the second most important factor, and so on through number 6, which is the least important factor to you.

_____ Understanding speech better
_____ Inconspicuous Appearance
_____ Comfort
_____ Function in noisy environment
_____ Cost
_____ Service

Patient Signature _____ **Date** _____