



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: \_\_\_\_\_  
 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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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:

\_\_\_\_\_ **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 your claim. 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 the fitting of a hearing aid, a 50% deposit is required in full.** We will then bill your insurance and issue you a refund once your insurance pays 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. We accept Visa, Mastercard, personal checks and cash. There will be a fee of \$50.00 for any returned checks.

\_\_\_\_\_ **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 \_\_\_\_\_



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

(see next page)

	YES	NO
Have you ever had a skull fracture/temporal bone fracture? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel fullness or pressure in your ears? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, which ear? _____ How often? _____		
Do you have dizziness or vertigo? .....	<input type="checkbox"/>	<input type="checkbox"/>
If so, last episode? _____ How long did it last _____		
Do your ear canals itch? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have sinus or allergy problems? .....	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently smoking cigarettes? .....	<input type="checkbox"/>	<input type="checkbox"/>
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? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel fullness or pressure in your ears? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, which ear? _____ How often? _____		
Does a hearing problem cause you difficulty when visiting friends or relatives? .....	<input type="checkbox"/>	<input type="checkbox"/>
Does a hearing problem cause you to attend social gatherings less often than you would like? .....	<input type="checkbox"/>	<input type="checkbox"/>
Does a hearing problem cause you difficulty when listening to TV or radio? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty hearing women or children? .....	<input type="checkbox"/>	<input type="checkbox"/>
Does a hearing problem cause you difficulty when in a restaurant with friends or relatives? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel embarrassed, frustrated and/or angry about your hearing problem? .....	<input type="checkbox"/>	<input type="checkbox"/>
Does your problem affect your family or relationships? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty hearing on the telephone? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, which ear do you use on the telephone? (check one) <input type="checkbox"/> right <input type="checkbox"/> left		
Do you wear hearing aids? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, check one: <input type="checkbox"/> left only <input type="checkbox"/> right only <input type="checkbox"/> both ears		
What year did you buy your hearing aids? _____		

(see next page)

	<b>YES</b>	<b>NO</b>
Approximately how many hours a day do you wear them? _____		
Are you currently satisfied with your hearing aids? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any problems with your hearing aids? .....	<input type="checkbox"/>	<input type="checkbox"/>
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)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
TELEVISION	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
RESTAURANTS	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
CHURCH	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
MEETING/GROUPS	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
WORK PLACE	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
TELEPHONE	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
CAR	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
MALE VOICE	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
FEMALE VOICE	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
CHILD'S VOICE	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
OTHER (please explain below)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 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 | _____ Function in noisy environment |
| _____ Inconspicuous appearance    | _____ Cost                          |
| _____ Comfort                     | _____ Service                       |

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_