REGISTRATION

(PLEASE PRINT)

New York Speech and Hearing, Inc.

Dr. Melissa E. Heche

Doctor of Audiology/Voice & Swallowing Pathologist

271 Madison Ave., Ste. 1405 — New York, NY 10016

Telephone: (212) 260-1414

Fax: (212) 260-7676

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Partnered for _____ years ☐ Minor

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

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Date: _____

Last Name: _____ **First Name:** _____ **DOB:** _____ **SSN:** _____

Reason for Visit: _____

Referred By: _____ **Ref Physician's Tel:** _____

Ref Physician's Address: _____

Primary Care Physician: _____ **PC Physician's Tel:** _____

Physician's Address: _____

Medications: (List all medications you are taking)

☐ None

_____

_____

_____

Allergies: (To medication or substances)

☐ None

_____

_____

_____

Social History

Do you smoke? ☐ Yes ☐ No Did you smoke? ☐ Yes ☐ No

If you ever smoked, when did you stop? _____

Do you drink? ☐ Yes ☐ No If so, how many drinks per day? _____

Do you have or have you ever used IV drugs? ☐ Yes ☐ No

Past or Current Medical Illness

☐ Hypertension (high blood pressure,)
☐ Lung Disease (COPD, asthma)
☐ Heart Disease
☐ Arthritis
☐ Diabetes
☐ Environmental Allergies
☐ Cancer (type) _____
☐ Bleeding Disorder
☐ Neurological Disorder
☐ Kidney Disease
☐ Glaucoma
☐ Thyroid Disease
☐ Elevated Cholesterol
☐ Stroke

Otologic Symptoms

☐ Ear Pain
☐ Discharge
☐ Dizziness/Imbalance
☐ Ringing/Noises/Tinnitus
☐ Pressure

Do you have a pacemaker? ☐ Yes ☐ No Any problems with hearing? ☐ Yes ☐ No

Hospitalizations/Surgeries:

Year:	Reason:	Reason for hospitalization / TYPE of surgery
_____	_____	_____
_____	_____	_____

Review of Systems: Do you experience any of the following?

☐ Fever/Chills
☐ Weight Loss
☐ Loss of Appetite
☐ Shortness of Breath
☐ Muscle Weakness
☐ Arthritis/Joint Pain
☐ Easy Bruising
☐ Depression
☐ Palpitations
☐ Chest pains
☐ Heartburn/Indigestion
☐ Headache
☐ Eye Problems
☐ Sinus Problems
☐ Frequent Urination
☐ Painful Urination

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Family History: Please check if your relatives have had

☐ Hypertension	☐ Anemia	☐ Cancer (type) :	☐ Other:
☐ Stroke	☐ Asthma	_____	_____
☐ Heart Disease	☐ Autoimmune Disease	_____	_____
☐ Diabetes	☐ Hearing Loss	_____	_____

Ten Ways to Recognize Hearing Loss

The following questions will help you determine if you need to have you hearing evaluated by a medical professional:

1. DO you have a problem hearing over the telephone?
   ☐ Yes ☐ No
2. DO you have trouble following the conversation when 2 or more people are talking at the same time?
   ☐ Yes ☐ No
3. DO people complain that you turn the TV volume up too high?
   ☐ Yes ☐ No
4. DO you have to strain to understand conversation?
   ☐ Yes ☐ No
5. DO have trouble hearing in a noisy background?
   ☐ Yes ☐ No
6. DO you find yourself asking people to repeat themselves?
   ☐ Yes ☐ No
7. DO many people you talk to seem to mumble (or not speak clearly)?
   ☐ Yes ☐ No
8. DO you misunderstand what others are saying and respond inappropriately?
   ☐ Yes ☐ No
9. DO you have trouble understanding the speech of women and children?
   ☐ Yes ☐ No
10. DO people get annoyed because you misunderstand what they say?
    ☐ Yes ☐ No

If you answered "Yes" to three or more of these questions, it is recommended that you see an audiologist or otolaryngologist (ear, nose, and throat specialist) for an evaluation.

Patient's Signature: _____ **Date**: _____

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Notice of Privacy Practices Acknowledgment / Patient Authorization Form

I hereby authorize New York Speech and Hearing, Inc. to use or disclose my personal health information for the purposes and parties below.

A healthcare provider for treatment, healthcare clearing houses (billing purposes), individual or group plans that provide or pay for the cost of medical care; such as employee welfare benefit plans, health insurance issuers, other property and casualty carriers and:

_____

_____

The information is being requested for the following purpose(s):

_____

_____

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting the office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and longer protected by HIPPA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is used for research-related treatment, in which case you may refuse to provide that research-related treatment).
- I understand that you will receive compensation from a third party for the use or disclosure of my information.

Patient Name: _____
Patient Signature: _____ **Date**: ___ / ___ / ____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this origination at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how private my information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Name: _____ **Relationship to patient**: _____
Signature: _____ **Date**: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:___/___/___ Initials:_____

Reason:_____

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PAYMENT POLICY

THIS PAYMENT POLICY APPLIES TO ALL VISITS MADE TO OUR OFFICE.

Professional services rendered are charged to the patient. The patient is responsible for all fees regardless of insurance coverage as confirmation of coverage is not a guaranty of payments. **It is the responsibility of the patient to know the benefits and exclusions of their insurance coverage.** If services are provided through a managed care plan that our office participates in, then the patient is responsible for their co-payment and referral. The patient MUST have their insurance card(s) and, if required, referral at the time of the visit. Please note that deductibles, out of pocket expenses, co-insurance amounts, and non-covered services include 'patient responsibility,' 'patient payable,' 'customer amount,' 'customer liability,' etc. Services not covered will be billed directly to the patient.

We do not accept assignment for any insurances in which we do not participate. There are NO exceptions to this policy. Insurance is a form of reimbursement to you and not a form of payment to us.

MEDICARE PATIENTS – It is your responsibility to obtain a script from your primary care physician requesting a hearing evaluation. This must be in hand at the time of the visit.

METHODS OF PAYMENT – We accept cash, check, Visa, and MasterCard. Returned check fee for any reason is $25.00.

By reading and signing this document, I fully understand my responsibilities described in the above policy. I also realize that non-covered services, co-insurance amounts, and deductibles will be billed directly to me. Co-pays and out-of-pocket expenses are due at the time each service.

_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

_____

PRINT NAME OF PATIENT