HIPAA RECEIPT AND ACKNOWLEDGEMENT

Indiana Ear Notice of Privacy Practices (HIPAA) has been offered to me. I understand I have the right to review the Notice of Privacy Practices (HIPAA) prior to signing this document and by signing this document, acknowledge **only** that I have been offered the Notice of Privacy Practices (HIPAA) or have declined the offer.

Indiana Ear reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

☐ **Check here if you don't want a copy of the HIPAA Notice**

OR

☐ **Check here if you want a copy of the HIPAA Notice**

______________________________	______________________________
Signature of Patient	Signature of Personal Representative
________________	______________________________
Patients Date of Birth	Description of Personal Reps. Authority
________________	
Date	

I authorize the following person(s) minimal access (does not include copies of medical records) to my protected health information (PHI):

Name	**Date of Birth**	**Home Phone Number**
______________________________	____________	__________________
______________________________	____________	__________________
______________________________	____________	__________________
______________________________	____________	__________________

Patient's signature: ____

For authorization to release limited PHI to the above listed individuals:

☐ I **authorize** communications between me and Indiana Ear by e-mail or text messaging. **(I understand that communications by e-mail or text may not be a secured means of communications)**

☐ I **do not want** communications via e-mail or text messages.

If no choice is made above on receiving e-mail or text messages, we will not communicate with you by either means.

Consent to Treat/Patient Financial Responsibility

CONSENT FOR CARE AND TREATMENT
I, the undersigned do hereby agree and give my consent for Indiana Ear to provide to the undersigned patient: audiology, medical services, and minor office procedures including but not limited to cerumen removal, paper patch placement, tube removal, and removal of a foreign body. This service is considered medically necessary and proper in the diagnosing or treatment of my audiology or other condition. I understand that my medication history will be downloaded from the Pharmacy Benefit Manager to aid in proper treatment plans and to optimize your care.

FINANACIAL POLICY STATEMENT
We bill your health insurance company as a courtesy to you. You are responsible for any co-pay or deductible at the time of service. We require that payment of your estimated share be made at the time of your appointment. In the event your insurance company requests a refund of payment or denies coverage for your service, you will be responsible for the balance due. Denials based on "Usual and Customary" will be your responsibility pursuant to any managed care contract in place. If payment is made to you for services provided by Indiana Ear, you are obligated to promptly pay for those services.

Pre-certification is not a guarantee of payment of benefits. Any questions regarding your insurance coverage needs to be directed your insurance carrier. You will be responsible for all fees incurred for collections of monies owed including collection agency fees and/or court costs.

NO SHOW FEES. An appointment that is cancelled within 24 hours of the appointment or the patient does not come to the appointment, there will be a **$50 no show** fee assessed. The space that is schedule is reserved for you. When it is cancelled upon short notice, we are unable to fill the appointment time. This fee is not covered by insurance and will be the responsibility of the patient. If a surgery is cancelled within a week of the surgery date, a **$150 no show** fee will be assessed. The nurse and schedulers work diligently to get precertification completed, pre-operative clearances, and coordinate with the surgical facility, along with other paperwork needed to be completed in advance of the surgery date. When a surgery is cancelled 5 business days prior or less of the surgery, we are unable to fill the surgical slot. Please be courteous and plan your time in advance. THIS FEE IS NOT COVERED BY INSURANCE AND IS THE PATIENT'S RESPONSIBILITY. Furthermore, if there are 3 consistent no shows, you will be given a 30 day notice of discharge from the practice.

FMLA AND DISABILITY PAPERWORK
The expenses associated with the completion of disability and FMLA paperwork are not covered by your insurance company. Charges apply for ALL disability and FMLA paperwork completed by our office. It is the patient's responsibility to provide our office with the paperwork that must be completed, due dates, and accurate fax numbers and/or mailing addresses for the paperwork destination. Our standard charge is $20.00 per set of paperwork completed.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION
I hereby authorize release to my insurance company of all information necessary for the payment of benefits. I hereby assign payment of benefits by my insurance company or Medicare to Indiana Ear.

Patient Printed Name______________________________________DOB__________Date__________

Patient/Representative Signature____

Relationship to the Patient____

Demographic Information

Date:_____________

First Name:___________________________ MI: _______ Last Name:___________________________________Sex: M__ F___

Preferred Name: ___________________________________DOB: _______/________/_________ SSN:_______-______-________

Guardian Name (If Patient is a Minor):____DOB:_____________________

Address:____City: ______________________State: ______ Zip Code:___________

Cell Phone: ___________________________Home Phone:_______________________Work Phone:_______________________

Preferred Method of Contact: Home______ Cell______Work______

Preferred Method of Contact: Phone______Text_______ Email____

Email Address____

Marital Status: Single_____ Married_____Widowed_____Divorced______

Preferred Language: (choose one) English____Spanish____Burmese______Other__________

Race: White____ African American____ Hispanic____ American Indian/Alaskan____ Asian___

Ethnicity: Hispanic/Latino____ Non-Hispanic/Latino____ Other____

Emergency Contact #1 (First & Last Name): ____

Relationship: ____________________ Phone Number: ____

Responsible Party Employer:____Employer Phone Number:__________________

Care Team Information:

Primary Care Physician:____

Referring Physician:____

Other Physicians:____

Preferred Pharmacy Name: ____________________________Location:______________________________________

Preferred Imaging Center:____

Preferred Laboratory:____

Patient/Representative Signature:____Date:______________

How Did You Hear About Us?

Referring Physician______Family/Friend______Advertising_______Insurance Company_______

Patient Name:______________________

DOB:____________

Date:____________

Insurance Information

Primary Insurance Coverage:____

ID Number:______________________________Group Number:_________________________

Policy Holder Name: _________________________________DOB:_______________________

Relationship to patient: ______________________ SSN: __________- _________ - __________

Contact Phone Number:____

Employer: ____

Secondary Insurance Coverage:____

ID Number:______________________________Group Number:_________________________

Policy Holder Name: _________________________________DOB:_______________________

Relationship to patient: ______________________ SSN: __________- _________ - __________

Contact Phone Number:____

Employer: ____

Notice Regarding Insurance Claims / Payments

If we are filing insurance for your visit we must have complete information and any required referral at the time of the visit. If you cannot provide the information we will be unable to file your insurance, and payment in full will be required. It is your responsibility to make sure the physician's office has all information required information.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your plan deductible and / or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also be your responsibility. Your office visit copay is due at the time of visit and, in many cases, covers only the office visits charge. <u>Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance may apply.</u>

For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon request.

I have read the above information and understand that I am responsible for payment for services I receive.

Patient/Guardian Signature_______________________________________Date_____________

Current Medications and Allergies

Patient Name_________________________DOB_________Date__________

Medications

Medication	Dosage	How Often

Medication Allergies

Medication	Reaction

Patient Health History Form

Date ____/____/____

Our concern is your hearing. To better help you, we ask that you fill out this questionnaire to describe how 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 and return to the front desk.

Patient Name ________________ ________________ ________ Date of Birth ____/____/____
First Last MI MM DD YYYY

MEDICAL/AUDIOLOGICAL HISTORY

Will this be the first time you've had a hearing test? ☐ YES ☐ NO
If no, what year were you last tested? __________

Have you ever had ear surgery? ☐YES ☐ NO

Do you experience noises or ringing in your ears? ☐YES ☐ NO

Did you have chronic ear infections as a child or adult? ☐YES ☐ NO

Do you have a family history of hearing loss? ☐YES ☐ NO

Do you have a history of noise exposure? ☐YES ☐ NO

Have you had any trauma to the head? ☐YES ☐ NO

Any recent pain or drainage from the ear canals? ☐YES ☐ NO

Do you experience dizziness? ☐YES ☐ NO

Do you have sinus or allergy problems? ☐YES ☐ NO

Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors? ☐YES ☐ NO

Does a hearing problem cause you to attend social events less often than you would like? ☐YES ☐ NO

Does a hearing problem cause you difficulty when listening to TV or radio? ☐YES ☐ NO

Does a hearing problem cause you difficulty when in a restaurant with relatives or friends? ☐YES ☐ NO

Which ear is your better hearing ear? ☐Left ☐Right ☐Equal

Which ear do you use with the telephone? ☐Left ☐Right

What do you believe caused your hearing problem? ____________________

Do you wear hearing devices?

If yes, do you have any problems with your hearing devices? ____________________

If applicable, in which ear(s) do you wear your hearing devices? ☐Left ☐Right ☐Both

What year did you buy your hearing devices? __________ Approx. how many hours a day do you wear them? ______

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 ____________________

____

9604 Coldwater Road, Suite 103, Fort Wayne, Indiana 46825
Phone: 260-489-2693
Fax: 260-755-6235

Out-Of-Network Agreement

I understand that Indiana Ear is out-of-network with all Humana Insurances. I understand I am financially responsible for my services at Indiana Ear.

Please initial your payment choice.

______I will be paying out-of-pocket for my services. I understand the service claim will not be filed with insurance.

______I have obtained an out-of-network authorization from my Primary Care Physician. However, whatever insurance does not pay, I understand I am responsible for the remaining balance.

______I would like Indiana Ear to file with my insurance with full knowledge Indiana Ear is out-of-network and may not pay. I understand I do not have an out-of-network authorization from my Primary Care Physician. I agree to pay the full cost of the visit, if insurance denies the claim or does not pay.

Patient Printed Name:___________________________________DOB:____________________

Patient/Guardian Signature:______________________________Date:____________________

Relationship to the Patient:____

Patient Name ____ DOB _____________

Family History

Please Check Mark If Any Immediate Family Members Have The Following Disorders

☐ Allergic Rhinitis
☐ Allergies
☐ Anxiety
☐ Asthma
☐ Bell's Palsy
☐ Blood Coagulation Disorder
☐ Cerebrovascular Accident
☐ Depressive Disorder
☐ Diabetes Mellitus
☐ Headache
☐ Hearing Loss
☐ Hypertensive Disorder
☐ Impairment of Balance
☐ Migraine
☐ Meniere's Disease
☐ Otosclerosis
☐ Tinnitus

Your Surgical History

☐ Abdominal Surgery
☐ Adenoid Surgery
☐ Appendectomy
☐ Bariatric Surgery
☐ Caesarean Surgery
☐ Cataract Surgery
☐ Cervical Spine Surgery
☐ Coronary Artery Stent
☐ Ear Surgery
☐ Ear Tubes
☐ Eye Surgery
☐ Heart Surgery
☐ Hysterectomy
☐ Kidney Surgery
☐ Lumbar Spine Surgery
☐ Nasal Surgery
☐ Neurosurgery
☐ Orthopedic Surgery
☐ Other
☐ Pacemaker
☐ Septoplasty
☐ Sinus Surgery
☐ Thyroid Surgery
☐ Tonsillectomy
☐ Vascular Surgery

Your Medical History

☐ Acid Reflux
☐ Allergies/Hayfever
☐ Anemia
☐ Anesthesia Complications
☐ Anxiety Disorders
☐ Asthma
☐ Bleeding Disorders
☐ Cancer

What Type: _____________

How Long: _____________

☐ Depression
☐ Developmental Delay
☐ Diabetes
☐ Emphysema
☐ Glaucoma
☐ Headaches
☐ Hearing Loss
☐ Heart Attack
☐ Heart Disease
☐ Heart Problems
☐ Hypertension
☐ Immune System Disorder
☐ Kidney Disease
☐ Migraines
☐ Speech Delay
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis
☐ Others_____________

Your Social History

Caffeine Intake
☐ None
☐ Occasional
☐ Moderate
☐ Heavy

Alcohol Intake
☐ None
☐ Occasional
☐ Moderate
☐ Heavy

Tobacco Smoking Status
☐ Never Smoked
☐ Former Smoker
☐ Current Every Day Smoker
☐ Current Some Days Smoker
☐ Smoker (current Status Unknown)
☐ Unknown If Ever Smoked

Noise Exposure
☐ Industrial
☐ Firearms
☐ Explosions or Blasts
☐ Other

Occupation _____________

Phone: (260) 387-5820
Web: www.IndianaEar.com

Thank you for choosing Indiana Ear!
Please review the following information regarding your upcoming appointment.

To Do List
BEFORE Your Appointment!

☐ **Obtain Any Brain Imaging on Disc and BRING WITH YOU.**

☐ **Complete the New Patient Packet and bring with you.**

APPOINTMENT DATE: ____

ARRIVAL TIME: ____

APPOINTMENT TIME: ____

☐ AUDIOGRAM (HEARING TEST) INFORMATION: If checked, you have been scheduled for a comprehensive hearing test in conjunction with your consultation with Dr. Disher. This updated, in-house test is necessary, even if you have recently had a hearing screening or test elsewhere.

Fort Wayne Office
9604 Coldwater Road
Suite 101
Fort Wayne, IN 46825

South Bend Office
6301 University Commons
Suite 360
South Bend, IN 46635

Warsaw Office
1610 E.Center St.
Warsaw, IN 46580

We look forward to meeting you at your upcoming appointment. Please visit our website, www.IndianaEar.com, to view office maps and other helpful information. Driving directions to our office locations are also printed on the back of this form. Thank you again for choosing Indiana Ear!

Fort Wayne Office Location, 9604 Coldwater Road, Suite 101 - Fort Wayne, IN 46825

<u>From the Coldwater Road Exit (Exit 312) via I-69:</u>

1. Take Exit 312/Coldwater Road NORTH exit from I-69.
2. Continue on Coldwater Road for 2.2 miles.
3. WaterStone Professional Park will be on your right, at the Till Road traffic light.
4. Our office is located in the 9604 building. Suite 101 is the first office on the left upon entering the building.

<u>From the Dupont Road Exit (Exit 316) via I-69:</u>

1. Take Exit 316 from I-69. From exit ramp, head WEST on Dupont Road.
2. Continue on Dupont Road approximately 1.5 miles to Coldwater Road.
3. Turn left (south) on Coldwater Road. Continue 0.7 miles.
4. WaterStone Professional Park will be on your left, at the Till Road traffic light.
5. Our office is located in the 9604 building. Suite 101 is the first office on the left upon entering the building.

South Bend Office Location, 6301 University Commons, Ste 360 – South Bend, IN 46635

The office is located behind the University Park Mall, across the street from Sears on State Road 23.

From I-80/I-90 Toll Road:

1. Take Exit 83 towards Mishawaka
2. Merge onto US 331/Capital Ave towards State Route 23
3. Turn left onto State Route 23 and continue 2.2 miles
4. Take a left to continue on State Route 23 (just past Grape Road)
5. The office will be 0.5 miles down on your right.

Warsaw Location:

1. Take State Road 30W.
2. Turn Left onto Center St.
3. Office is located inside Dr.Engelberth's Hearing Clinic.