

Rochester Hearing and Speech Center

1000 Elmwood Avenue, Suite 400
Rochester, NY 14620-3092
(585) 271-0680
TTY: 442-2985

3199 W. Ridge Road
Rochester, NY 14626
(585) 723-2140
TTY: 723-3856

1170 Ridge Road
Webster, NY 14580
(585) 872-8073
TTY: 442-2985

ADULT AUDIOLOGY HISTORY QUESTIONNAIRE

Name: _____ DOB: _____ Date: _____

1. Which of the following problems most concern you? (please check all that apply)

- Hearing loss Dizziness Ear/Head Noise Hearing in Background Noise

Other (specify): _____

What do you think caused your hearing loss? _____

2. Hearing History

- a. Have you had your hearing tested previously? Yes No

If yes, when and where? _____

What were the results? _____

- b. If you think you have a hearing problem, did it occur: Suddenly Gradually Unsure
When did it begin: Less than 1 year ago 1 to 5 years ago Over 5 years ago Birth

Has it gotten worse over time? Yes No Unsure

Does it fluctuate over time? Yes No Unsure

Family history of hearing loss? Yes No Unsure

From which ear do you hear better? Right Left Both the same

- c. Have you ever been exposed to loud noises? Yes No If so, how long? _____

Did/do you use hearing protection in noise? Yes No Occasionally

- d. If you have worn hearing protection, for how many years have you done so? _____

3. Medical History

- a. If you have/or have had any of the following, please check all that apply:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Ear Surgery | (<input type="checkbox"/> L <input type="checkbox"/> R) | <input type="checkbox"/> Family history of hearing loss | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Ear injury | (<input type="checkbox"/> L <input type="checkbox"/> R) | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Blood thinner medications |
| <input type="checkbox"/> Ear fullness/pain | (<input type="checkbox"/> L <input type="checkbox"/> R) | <input type="checkbox"/> History of noise exposure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Excessive ear wax | (<input type="checkbox"/> L <input type="checkbox"/> R) | <input type="checkbox"/> Allergies/sinus problems | <input type="checkbox"/> Uses/Used Hearing Aid |
| <input type="checkbox"/> Tinnitus | (<input type="checkbox"/> L <input type="checkbox"/> R) | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Other (see comments) |

- b. Do you take any medications regularly? Yes No

Explain: _____

4. Hearing Aid Information

- a. Have you ever used a hearing aid? Yes No If yes, how long? _____

- b. Are you using a hearing aid now? Yes No

If yes, Which ear is aided? Right Left Both

How old is/are the hearing aid(s)? _____

Are you satisfied with the hearing aid(s)? Yes No

- c. Would you wear new hearing aids if recommended? Yes No Unsure

5. What do you hope to learn from today's visit? _____

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Hearing Assessment Pre-Questionnaire

Client Name:

Date:

Do you feel you have a hearing loss? Yes Sometimes No

Do others feel that you have a hearing loss? Yes Sometimes No

If you answered no to both of these questions, you can stop here.

If you answered yes or sometimes to either or both of these questions, please answer the following questions. If you currently wear hearing aids, please answer the questions as they apply to you when you wear them.

- | | Yes | Sometimes | No | Doesn't Apply |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Problems with hearing greatly upset me..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Listening tires me out..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. I wish I could hear better when I am with other people..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. I often pretend I hear someone say something when I really don't..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. I avoid being with others because of my hearing..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. My level of hearing interferes with: | | | | |
| a. my personal life (interactions with family, friends, etc.....) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. my social life (parties, movies, religious services, etc.)..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. my ability to understand important information (doctor's visits, bank tellers, waiters/waitresses, etc.)..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. my job performance..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. I hear what others say, but it's not always clear..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. I find I have to ask people to repeat themselves..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. I have trouble hearing when someone talks softly..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. I have trouble hearing others speak from another room..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. I have trouble hearing in noisy places..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. I have difficulty hearing on the telephone..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. My family/friends say I have the TV or radio too loud..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. I have difficulty hearing the speaker in a large group setting (religious services, theater, lecture)..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. I have difficulty hearing the doorbell or telephone ring..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. If hearing aids would help me, I would wear them: | | | | |
| a. in public..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. at work..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. with family and friends..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. at home..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Do you currently wear hearing aids? Yes No

Form F.1

AUD-156:2-08

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ROCHESTER HEARING AND SPEECH CENTER

**Consent to Use and Disclose Protected Health Information for Evaluation,
Treatment, Payment and Health Care Operations**

Name: _____
(Please print)

Date of Birth: _____

I understand that my signature on this consent is required in order for me to receive services from Rochester Hearing and Speech Center. In addition, I authorize the use and disclosure of my Protected Health Information (PHI) by Rochester Hearing and Speech Center's staff for purpose of evaluation, treatment, payment and health care operations.

- I understand that this information may be used or disclosed by Rochester Hearing and Speech Center to
- * plan my care and treatment;
 - * communicate among various health care professionals who are involved in my care or treatment;
 - * obtain payment for care provided by Rochester Hearing and Speech Center or for the payment activities of another health care provider or entity;
 - * provide information to my health insurance company or plan;
 - * assess and review the quality of my care. Further information on uses and disclosures of PHI is included in Rochester Hearing and Speech Center's Notice of Privacy Practices.

As part of RHSC's comprehensive services, we will release the findings of your reports to those professionals involved in your care. Reports will automatically be sent to the physician listed and to referral sources. To send these reports, we must have your authorization to do so. This authorization will be valid through this specific course of treatment.

Please list any other specific individuals/facilities you would like information shared/sent to. (e.g.. relatives, day care providers, etc.):

If there are any restrictions, please indicate:

I understand that I may cancel this authorization at any time by submitting a written request and that the release of HIV-related information requires additional authorization.

Payment, excluding that covered by insurance, is due at the time of service. If, for any reason, your insurance refuses to pay us for all or part of the service, you will be billed for the service provided. Payment will be due within 30 days of billing. If payment is not received within 30 days, your account will be forwarded to a collection agent, and further services will not be provided until your account is satisfied.

Parent or Legal Guardian *(Print)*

Date

Signature

Relationship

ROCHESTER HEARING AND SPEECH CENTER

Notice of Privacy Practices

This notice describes how your Protected Health Information may be used and disclosed and how you can access this information. Please review it carefully.

Rochester Hearing and Speech Center uses your Protected Health Information (PHI) for treatment, to obtain payment for our services and for our operational purposes, such as improving the quality of care we provide to you. We are required by law to maintain the privacy of your PHI, provide you with this Notice and abide by its terms which describes our health information privacy practices and those of affiliated health care providers that provide care at our facility. If we make any material changes to this Notice, you will be notified.

With your consent, we may use and disclose your PHI for specific reasons:

- **For Treatment:** Our staff and affiliated health care professionals may review and record information in your record about your treatment and care. We will use and disclose this health information to health care professionals in order to treat and care for you. We may contact you to provide appointment reminders.
- **For Payment:** We will bill your insurance company, you directly, or another person that may be responsible for payment of your account. We may need to contact your health plan to see if they will pay for your visits.
- **For Health Care Operations:** We may use and disclose your PHI to others for our agency's business operations. For example, we may use PHI to evaluate our agency's services, including the performance of our staff, and to educate our staff.

Disclosures for Other Specific Purposes:

We may use and disclose PHI about you, without specific consent for the following:

- **Business Associates:** We may share your PHI with our vendors and agents who help us with obtaining payment or carrying out our business functions.
- **Family and Significant Others Involved in Your Care:** Unless you object, we may disclose your PHI to a family member or significant other who is involved in your care or payment for that care.
- **Disaster Relief:** In the event of an unforeseen disaster, we may disclose your PHI to an organization assisting in disaster relief.
- **Public Health and Safety Activities:** We may disclose your PHI for public health activities including the reporting of disease, injury, vital events and the conduct of public health surveillance, investigation and/or intervention.
- **Health Oversight Activities:** We may disclose your PHI to health oversight agencies to conduct audits, investigations, inspections and licensure actions or other legal proceedings.
- **Reporting Victims of Abuse or Neglect:** We may be required to disclose your PHI if we feel that you have been abused or neglected.
- **Law Enforcement:** We may disclose your PHI for certain law enforcement purposes or other specialized governmental functions.
- **Deceased person information:** We may disclose your PHI to coroners, medical examiners, and funeral directors.
- **Judicial and Administrative Proceedings:** We may disclose your PHI in the course of certain judicial or administrative proceedings.
- **Research:** In general, we will request that you sign a written authorization before using your PHI or disclosing it to others for research purposes. However, we may use or disclose your PHI without your written authorization for research purposes provided that the research has been reviewed and approved by a special Corporate Compliance/HIPAA or Institutional Review Board.
- **To Avert a Serious Threat to Health or Safety:** We may be required to disclose your PHI if, in our opinion, doing so will help avert a serious threat to the public.

- **Military Personnel:** We may disclose your PHI to the appropriate command authorities.
- **Worker's Compensation:** We may use or disclose your PHI to comply with laws relating to workers' compensation or similar programs.
- **National Security and Intelligence Activities: Protective Services:** We may disclose PHI to authorized federal officials who are conducting national security and intelligence activities.
- **As Required by Law:** We will disclose your PHI when requested by the law to do so.
- **Marketing and Fundraising:** We may contact you regarding RHSC's services, to share community news or to participate in fundraising activities. You may request to not receive these communications by notifying the person under Questions/Complaints below.

We will use and disclose your PHI other than as described in this Notice or required by law only with your written Authorization. You may revoke your Authorization to use or disclose PHI in writing, at any time. To revoke your Authorization, contact the Medical Records Department. If you revoke your Authorization, we will no longer use/disclose your PHI for the purposes covered except where we have already relied on the Authorization.

CLIENT RIGHTS:

You have the following rights with respect to your health information. If you wish to exercise any of these rights, you should make your request to the Medical Records Department:

- **Right of Access to Protected Health Information:** You may request access to inspect and copy your PHI maintained in our records, including medical and billing records. Your request must be in writing. We will act on your request within 10 days after we receive it. If we must deny your request, we will send you a written denial. If this happens, you may request a review of the denial. We may charge you a fee for this service.
- **Right to Request Restrictions:** You may ask us to limit our use or disclosures of your PHI. We will abide by your request except as required by law, in emergencies, or when the information is necessary to treat you. Your request must be in writing, describe the information that you want restricted, state if the restriction is to limit our use or disclosure and state to whom the restriction applies.
- **Right to an Accounting of Disclosures:** You may request a list of disclosures that we have made of your PHI over the previous six years. You may not request an accounting for date of service prior to April 14, 2003. Your first request within a 12-month period is free, but we may charge for additional lists within the same 12-month period.
- **Right to Request Amendment:** You may ask us to amend your health information if you believe that it is incorrect or incomplete. Your request must be in writing and must include a reason to support the amendment. We may deny your request and if we do so, will give you a written denial including reasons for the denial and an explanation of your right to submit a written statement disagreeing with the denial.
- **Right to a Paper Copy of This Notice:** You have the right to obtain a paper copy of this Notice by using the contact information. (You may also obtain a copy of this Notice at our website, www.rhsc.org.)
- **Right to Request a Confidential Communications:** We will make every effort to communicate with you in a confidential manner. You have the right to request that we communicate with you concerning personal health matters in a certain manner or at a certain location.

QUESTIONS/COMPLAINTS: Questions or complaints about this Notice of Privacy Practices or how Rochester Hearing and Speech Center handles your health information should be directed to: Rochester Hearing and Speech Center, Attn: Kathleen Gilman, 1000 Elmwood Avenue, #400, Rochester, NY 14620. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to the Secretary of the Department of Health and Human Services.

Effective Date: 4/13/03 (v.1)

Rochester Hearing and Speech Center Clients' Bill of Rights

Clients' rights. Policies and procedures shall be developed and implemented regarding the clients' rights. The operator shall have in effect a written statement of clients' rights which is prominently posted in client care areas and a copy of which is given to the client. Such statement shall include the clients' rights to:

- (a) receive service(s) without regard to age, race, color, sexual orientation, religion, marital status, sex, national origin or sponsor;
- (b) be treated with consideration, respect and dignity including privacy in treatment;
- (c) be informed of the services available at the center;
- (d*) be informed of the provisions for off-hour emergency coverage;*
- (e) be informed of the charges for services, eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care;
- (f) receive an itemized copy of his/her account statement, upon request;
- (g) obtain from his/her health care practitioner, or the health care practitioner's delegate, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the client can be reasonably expected to understand;
- (h) receive from his/her clinician information necessary to give informed consent prior to the start of any non-emergency procedure or treatment or both. An informed consent shall include, as a minimum, the provision of information concerning the specific procedure or treatment or both, the reasonably foreseeable risks involved, and alternatives for care or treatment, if any, as a reasonable clinician under similar circumstances would disclose in a manner permitting the client to make a knowledgeable decision;
- (i) refuse treatment to the extent permitted by law and to be fully informed of the clinical consequences of his/her action;
- (j) refuse to participate in experimental research;
- (k) voice grievances and recommend changes in policies and services to the center's staff, the operator and the New York State Department of Health without fear of reprisal;
- (l) express complaints about the care and services provided and to have the center investigate such complaints. The center is responsible for providing the client or his/her designee with a written response within 30 days if requested by the client indicating the findings of the investigation. The center is also responsible for notifying the client or his/her designee that if the client is not satisfied by the center response, the client may complain to the New York State Department of Health's Office of Health Systems Management;
- (m) privacy and confidentiality of all information and records pertaining to the client's treatment;
- (n) approve or refuse the release or disclosure of the contents of his/her medical record to any health-care practitioner and/or health-care facility except as required by law or third-party payment contract;
- (o) access his/her medical record pursuant to the provisions of section 18 of the Public Health Law, and Subpart 50-3 of this Title;
- (p*) authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors; and*
- (q*) make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the center.*

** Not applicable to RHSC*

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My signature below acknowledges that I have received a copy of Rochester Hearing and Speech Center's Notice of Privacy Practices and the Clients' Bill of Rights.

Client Name (*Print*)

Date

Client Signature

If child:

Parent or Legal Guardian (*Print*)

Date

Signature

Relationship to Client

For Facility Use Only:

Rochester Hearing and Speech Center made a good faith effort to obtain the above referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices.

Staff Member

Date