ROCHESTER
Hearing
&Speech
Center
Communication for Life

Dear:

Thank you for choosing Rochester Hearing and Speech Center for hearing services. To provide you with the best possible services, please complete the enclosed forms. In addition, please review the information on the Client Registration Form, make any additions or corrections and bring all the forms to the appointment. Please arrive 15 minutes early so that we can review the forms for completeness and accuracy.

A hearing assessment consists of a number of tests performed by a licensed, certified audiologist. These tests will determine hearing ability and guide recommendations for follow-up services, if indicated. Specifically, the audiologist will:

- Review the case history
- Perform the necessary tests to determine hearing acuity
- Review the test results and help you understand the findings and their implications
- Make appropriate recommendations

Testing and review will take approximately one hour. You are encouraged to ask questions at any point. Our goal is for you to be an active participant and make informed choices.

If you can't make the appointment, we request that you call our agency at 271-0680 at least 24 hours before the scheduled appointments so that we can make alternative scheduling arrangements.

If you have specific questions regarding the enclosed forms or payment, please contact us at 271-0680. We look forward to serving you.

Your appointment is scheduled for _____ at _____a.m./p.m.

(S/F332R pradm ltr 6/10)

ROCHESTER HEARING AND SPEECH CENTER

1000 Elmwood Avenue #400, Rochester, NY 14620 // Phone: (585) 271-0680 // Fax: (585) 442-4114
3199 W. Ridge Road, Rochester, NY 14626 // Phone: (585) 723-2140 // Fax: (585) 723-3557
1170 Ridge Road, Webster, NY 14580 // Phone: (585) 286-9373 // Fax: (585) 872-8075

Client Information *(person receiving services)* **Today's Date:** _____

Name: _____
Last *First* *Middle*

Phone: (home/cell) _____ (work) _____

Sex: ☐(M) ☐(F) Birthdate: _____

Home Address: _____
Street *Apt. No.*

_____
City *State* *Zip* *County*

Email address: _____

Emergency Contact: _____
Name *Phone Number* *Relationship*

How did you hear about Rochester Hearing and Speech Center?

☐ Insurance ☐ RHSC Website ☐ RHSC Internet Ad ☐ RHSC Radio Ad ☐ RHSC TV Ad

☐ Social Media ☐ Print Publication ☐ Community Based Site Visit ☐ RHSC Employee Referral

☐ Friend/Family ☐ EI/CPSE/CSE ☐ Physician Referral: _____
Name of Doctor

☐ Other: _____

Primary Care Physician Information:

Physician Name: _____

Address: _____

Telephone: (___) _____

Insurance Information:

Medicare *(Social Security System)*	**Primary Health Insurance**
Medicare No.: _____ *(i.e., 999999999A9)*	Insurance Company Name:
Subscriber Name: _____	Client ID No.: _____ *(i.e., 222222222-02)*
	Subscriber Name: _____
Medicaid *(NYS Dept. of Social Service)*	Relationship to Client: _____
Medicaid CIN No.: _____ *(i.e., AB00000C)*	Subscriber Employer: _____
2 Digit Sequence Number: _____	Specialist Co-Pay Amount: _____
Social Worker Name/Case Worker: _____	Annual Deductible: _____
Phone No.: (___) _____	

Rochester Hearing and Speech Center

1000 Elmwood Avenue, Suite 400, Rochester, New York 14620-3092 • Voice (585) 271-0680 • TTY (585) 442-2985
3199 W. Ridge Road, Rochester, New York 14626 • Voice (585) 723-2140 • TTY (585) 723-3856
1170 Ridge Road, Webster, NY 14580 (585) 286-9373

ADULT AUDIOLOGY HISTORY QUESTIONNAIRE

Name: _____ DOB: _____ Date: _____

1. **What concerns prompted you to schedule today's appointment?**

   _____

   _____

2. **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? _____

3. **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 overt ime? ☐ 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? _____

4. **Medical History**

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

   ☐ Ear Surgery (☐ L ☐ R) ☐ Family history of hearing loss ☐ High Blood Pressure

   ☐ Ear injury (☐ L ☐ R) ☐ Dizziness ☐ Blood thinner medications

   ☐ Ear fullness/pain (☐ L ☐ R) ☐ History of noise exposure ☐ Diabetes

   ☐ Excessive ear wax (☐ L ☐ R) ☐ Allergies/sinus problems ☐ Uses/Used Hearing Aid

   ☐ Tinnitus (☐ L ☐ R) ☐ Head Injury ☐ Balance Difficulty

   ☐ Other (see comments)

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

   Explain: _____

5. **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

6. **List your primary objective(s) you would like addressed:** _____

_____

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Hearing Assessment Pre-Questionnaire: Client

Name: _____ **Date:** _____

Do you feel you have any hearing difficulties? ☐ Yes ☐ Sometimes ☐ No

Do others notice you have hearing difficulties? ☐ Yes ☐ Sometimes ☐ No

	Yes	Sometimes	No	Doesn't Apply
1. Do you have trouble hearing when someone talks softly?	☐	☐	☐	☐
2. Do you hear what others say, but it's not always clear?	☐	☐	☐	☐
3. Do you have trouble hearing others speaking when they are not facing you?	☐	☐	☐	☐
4. Do you have to ask people to repeat themselves?	☐	☐	☐	☐
5. Do you have difficulty hearing on the telephone?	☐	☐	☐	☐
6. Do your family/friends say you play the TV/radio too loud?	☐	☐	☐	☐
7. Do you have difficulty hearing the doorbell/telephone ring?	☐	☐	☐	☐
8. Do you have trouble hearing others in noisy places or group settings (restaurant, party)?	☐	☐	☐	☐
9. Do you have difficulty hearing the speaker in a large group setting (religious services, theater, lecture)?	☐	☐	☐	☐
10. Does your level of hearing interfere with your personal or social life?	☐	☐	☐	☐
11. Does a hearing problem cause you to feel frustrated when talking to others?	☐	☐	☐	☐
12. Do you avoid being with others because of your hearing?	☐	☐	☐	☐
13. Do you currently wear hearing aids?	☐		☐	

Aud-156A: 10-27-11

ROCHESTER HEARING AND SPEECH CENTER

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

Name: _____ Date of Birth: _____
(Please print)

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. (ex. 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.

_____ _____
Signature Date

_____ _____
Patient/ Parent or Legal Guardian (Print) Relationship

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Consent for Clinical Services

Client Name: _____ Client Date of Birth: _____

I, _____, consent for the above named client to
(Client or Parent/Guardian/Person Authorized to Consent)

receive professional services at Rochester Hearing and Speech Center. I understand that Rochester Hearing and Speech Center is a provider of services within the disciplines of Audiology, Speech Language Pathology, Occupational Therapy, Physical Therapy, Special Education, Psychology and/or Hearing Aid Dispensing.

I hereby acknowledge that such consent will remain in effect unless and until I cancel such consent in writing.

_____
Signature of Client *or* Parent/Guardian/Person Authorized to Consent

_____ _____
Printed Name Date Signed

_____
Relationship to Client

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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.

Rochester Hearing and Speech Center accepts the following insurances: Excellus, MVP, NYS Empire, United Health Care, Aetna

Client/*Child Name (*Print*) _____ Date _____

Client Signature _____

*If child:

**or Legal Guardian/POA

Parent or Legal Guardian (*Print*) _____ Date _____

Signature _____ Relationship to Client/*Child _____

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 above.

Staff Member _____ Date _____

FINANCIAL POLICY FOR ROCHESTER HEARING AND SPEECH CENTER (non-Medicaid)

Please read this entire document carefully. You must sign this form before we proceed with your care. Please address any concerns to our financial team.

Our primary goal is to provide the highest quality of healthcare, and in a gentle, efficient an enthusiastic manner. We will do our best to help you plan your investment in your hearing health based on your needs.

Please bring cash, check or credit card with you at the time of treatment.

Delinquent balances over 90 days old will be sent to collections. PLEASE NOTE THAT YOU WILL BE RESPONSBILE FOR ALL FEES INCURRED TO ATTEMPT TO COLLECT ON YOUR ACCOUNT.

A returned check fee of $35.00 (subject to change as bank fees increase) will be added to your account for any returned check. Before we accept another payment by check, the return fee must be paid in full by either cash or credit card.

MISSED/ CANCELLED/ BROKEN APPOINTMENTS

We REQUEST 24 hours in advance for rescheduling your appointment. Missed/no show appointments without a 24 hour prior notification will have a charge of $25.00 added to your account. If you have (3) three missed/no show appointments you will be discharged from our practice.

Co-pays are due at time of service, if you do not make a payment by end of business day you will be charged a $10.00 late fee.

OFFICE POLICY FOR PATIENTS WITH INSURANCE

Please bring your insurance card and any other information you may have from your insurance carrier to each appointment. Also, please let us know immediately of any changes in your insurance carrier or policy.

Your treatment plan is individually based on one's diagnosis, and is not based on your insurance benefits or lack of benefits. We make the best decision based on your needs.

We will always do our best to help maximize your insurance benefits.

Although we file your claims as a courtesy, your insurance policy is a contract between you, your employer and your insurance company. We may or may not be a participating provider for your insurance carrier.

_____ (initial here)

Rev: 4/26/18

Not all services are a covered benefit in all contracts. It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy. **We cannot act as a mediator with your carrier or employer.**

As a courtesy to all of our insured patients, we will file your insurance claims. You are responsible on the day of treatment for uncovered expenses.

Your claim will be filed immediately and all benefits are expected to be paid within 30-45 days. The filing of an insurance claim does not relieve you of your responsibility on your account. If the claim is not cleared by your carrier the unpaid portion will then become your responsibility. A statement will be then issued to you.

I understand and accept the financial policies listed above. I understand if I have any questions I can speak to a billing associate or the Office Manager. I agree to pay for all services rendered to avoid any additional fees. I understand that I am financially responsible for any and all charges of treatment and incurred fees, whether or not paid by insurance and I agree to pay for such charges in full. I also hereby authorize the release of pertinent medical information to the insurance carrier(s).

X_____ _____ _____

Patient (or parent of minor), POA, Legal Guardian Signature | Staff Initial | Date

X_____ _____

Please Print Name (from above signature) | Client Name

CLIENT REGISTRATION FORM (con'd.)

CLIENT NAME: _____

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Employment Status: ☐Full Time ☐Part Time ☐Unemployed ☐Retired ☐N/A

Client Employer: _____ **Occupation:** _____

.....

Meaningful Use for Medicaid/Medicare and Grant Funding Data

Rochester Hearing and Speech Center is funded in part by the United Way of Greater Rochester, as well as other private foundations, and for these funding purposes, the following information is gathered for statistical reports only, is voluntary, and is not shared by client name. Rochester Hearing and Speech Center also provides services under the auspices of Medicaid and Medicare, and these entities require documented attempt to gather data on race, ethnicity, and language. This information is strictly voluntary, and confidential.

If any area is unchecked, it will be assumed that you do not wish to report.

For Medicaid/Medicare and/or Grant Funding:

ETHNICITY: (check one)
☐Hispanic ☐Latino ☐Not Hispanic or Latino
☐Unreported

RACE: (check one)
☐White or Caucasian ☐Black or African American ☐Asian ☐Pacific Islander
☐Native American or Alaskan Native ☐Native Hawaiian ☐Multi-racial ☐Other
☐Unreported

PRIMARY LANGUAGE: _____

The following information is requested for purposes of Grant Funding only:

Household Income:

☐Less than $15,000 ☐$15,000 to $24,999 ☐$25,000 to $44,999
☐$45,000 to $74,999 ☐$75,000 or greater ☐Unknown

Number of people in the household: _____