Connect Hearing
YOUR HEARING PROFESSIONALS

Office Use Only
Location ID:
RBS Contact No.:

Intake Date:

Your Hearing Needs Assessment

Name: _____ Date: _____

1. What motivated you to set the appointment for your hearing test?

_____

2. What is your hearing aid experience?

☐ I have a hearing aid and use it regularly in my:

☐ right ear ☐ left ear ☐ both ears

☐ I have a hearing aid, but don't use it, or use it only occasionally.

☐ I have tried a hearing aid, but returned it for credit.

☐ I have inquired about hearing aids at another office(s), but did not purchase at the time.

☐ I have never used a hearing aid.

3. Please list top 3 situations where you would most like to hear better. Be as specific as possible.

- _____
- _____
- _____

4. What is your most important consideration regarding hearing aids? Please rank order the following factors with 1 as the most important and 4 as the least important. Place an X if the item has no importance to you at all.

☐ Hearing aid size and the ability of others not to see the hearing aids
☐ Improved ability to hear and understand speech
☐ Improved ability to understand speech in noisy situations (e.g. restaurants, parties, etc.)
☐ Cost of the hearing aid system

5. On a scale of 1 to 10, with 1 being the worst and 10 being the best, how would you rate your communication and hearing ability?

1 2 3 4 5 6 7 8 9 10

6. How well do you think hearing aids will improve your hearing? Mark an "X" on the line.

Not helpful at all _____ Greatly improve my hearing

7. If we find you a benefit from using hearing aids, how likely are you to trying them? Mark an "X" on the line.

Not very likely to try them _____ Very motivated to try them

Please check the box which corresponds to your ability to hear in the situations listed and check how often you are in that situation.

Listening Situation:	How well do you hear in this situation?			How often are you in this situation?		
	Poor	Fair	Good	Rarely	Sometimes	Often
Quiet Room (1-2ppl)	☐	☐	☐	☐	☐	☐
Restaurants	☐	☐	☐	☐	☐	☐
Television	☐	☐	☐	☐	☐	☐
Meeting / Lectures	☐	☐	☐	☐	☐	☐
Work Place	☐	☐	☐	☐	☐	☐
Telephone	☐	☐	☐	☐	☐	☐
Large Social Gatherings	☐	☐	☐	☐	☐	☐

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Confidential Client Information

Client Name			
Title	*First Name*	*Middle Name*	*Last Name, Suffix*

Preferred Name

Client Demographics		
		☐ Single ☐ Married ☐ Widowed ☐ Divorced
Date of Birth (mm/dd/yyyy)	*Gender*	*Marital Status*

Primary Language	*Occupation*

Client Address			
Street Address	*City*	*State*	*Zip*

Client Contact Information
☐ Cell ☐ Home ☐ Work
May we leave a message? ☐ Yes ☐ No
Primary Phone
☐ Cell ☐ Home ☐ Work
May we leave a message? ☐ Yes ☐ No
Secondary Phone
May we email you? ☐ Yes ☐ No
Email Address

Please be aware that information sent via email can be forwarded, intercepted, printed and stored by others. Email can also be widely broadcast and received by unintended recipients. Email to you will not be encrypted. We cannot guarantee the security of email sent over public networks to you.

Email may introduce viruses onto computer systems. Emails may also be used in court. Email, like almost all communication methods is vulnerable to human error and an incorrect address can be used to transmit incorrect information to an unintended recipient.

You may also communicate with Connect Hearing via telephone, US mail or in person during your visit. Email is not a substitute for care provided during an office visit. By providing your email address as a preferred method of communication, you acknowledge the risks of electronic communication and authorize Connect Hearing to use email to communicate with you. You may revoke this permission by contacting the Privacy Office at privacy@connecthearing.com

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Health History

Ear and Hearing History	
Which is your better ear?	☐Right ☐Left ☐ Unsure
Have you been diagnosed with a deformity of the ears?	☐No ☐Yes
Have you ever had ear surgery?	☐No ☐Yes
Have you ever had your hearing tested?	☐No ☐Yes
Do you have tubes in your ears?	☐No ☐Yes
Do you have any pain in your ears?	☐No ☐Yes
Do you hear a ringing, roaring, clicking, or hissing sound in your ears?	☐No ☐Yes
Have you experienced sudden or long-term dizziness?	☐No ☐Yes
Do you have a history of ear infections?	☐No ☐Yes
Have you had sudden or rapid hearing loss in the past 90 days?	☐No ☐Yes
Have you had drainage from either ear in the last 90 days?	☐No ☐Yes
Have you been exposed to very loud noises in the last 36 hours?	☐No ☐Yes
General Medical History	
Do you wear a pacemaker?	☐No ☐Yes
Are you currently on Blood Thinners?	☐No ☐Yes

Please provide any Specific Medical Conditions you would like us to know about

Provider History	
Name of Primary Care Physician (PCP):	
PCP's Phone Number:	( ) -
PCP's Address:	
Did your PCP refer you for this visit?	☐No ☐Yes
Name of Referring Physician::	☐No referring physician
Referring Physician's Phone Number:	( ) -
Referring Physician's Address:	
Have you seen a doctor specializing in diseases of the ear?	☐No ☐Yes (please write Dr.'s name below)
Have you ever seen a doctor for ear wax removal?	☐No ☐Yes

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Privacy Information & Consent for Treatment

Release of Information

I authorize the Connect Hearing staff to discuss my healthcare information, which may include the release of diagnosis, records, appointment, billing and claims information, with these people who are involved in my healthcare (e.g. husband, wife, son, daughter):

Name	*Relationship to Client*
Name	*Relationship to Client*

☐ **My information is not to be released to anyone**

This Release of Information will remain in effect until terminated by you in writing.

In Case of Emergency

	( ) -	
Name	*Phone Number*	*Relationship to Client*

Notice of Privacy Practices Acknowledgement

By signing below, you acknowledge that a copy of Connect Hearing's Notice of Privacy Practices was provided to you. This Notice provides information about how we may use and disclose your protected information; we encourage you to review it carefully. Further information about the Notice may be obtained by contacting our Privacy Office at privacy@connecthearing.com.

Date: _____

Name of Client or Legal Representative (please print): _____

Signature of Client or Legal Representative: _____

Relationship to Client: _____

Consent for Treatment

On behalf of myself or my dependents, if I choose to order earmolds, ear protection, or hearing instruments or have them repaired, I hereby authorize the relevant procedures to be performed, possibly including the insertion of silicone or similar material into the ear canal to obtain ear impressions. I understand that the cerumen removal process and/or the impression taking of my ear(s) is a semi- invasive procedure and that there is always the possibility of trauma to the skin in my ear canal or the tympanic membrane. For deep canal impressions, the procedure may be somewhat uncomfortable, but may be necessary for the effectiveness of the recommended hearing instrument. Small abrasions and slight bleeding are not uncommon. Otoscope inspection of my ear will be performed before and after the procedure. In the event of uncommon abrasion or trauma, I will be referred back to my PCP or an ENT for treatment. I have notified the clinician now present of any medications or conditions that could impact this procedure.

Date: _____

Name of Client or Legal Representative (please print): _____

Signature of Client or Legal Representative: _____

Relationship to Client: _____

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Insurance Coverage

Client Name: _____

Primary Insurance Coverage	Secondary Insurance Coverage
Insurance Company Name	*Insurance Company Name*
☐ Self	☐ Self
Policy Holder Name	*Policy Holder Name*
Policy Holder Date of Birth	*Policy Holder Date of Birth*
Policy Holder Address, City, State & Zip	*Policy Holder Address, City, State & Zip*
Group Number	*Group Number*
Subscriber ID Number	*Subscriber ID Number*

Please list any additional insurance coverage(s):

Insurance Agreement

Assignment of Benefits

I request that payment of authorized benefits be made on my behalf to Connect Hearing for any services furnished the client listed above by Connect Hearing personnel, and I assign my right to receive these payments to Connect Hearing. I authorize Connect Hearing to file an appeal on my behalf for any denial of payment and/or any adverse benefit determination related to services and care provided. If my Health Insurance Plan will not remit payment to Connect Hearing, I agree to forward to Connect Hearing all health insurance payments, which I receive for the services rendered by Connect Hearing and its personnel. I authorize Connect Hearing or its subcontractors to release to my Health Insurance Plan such information needed to determine these benefits or the benefits payable for related services.

Other Health Insurance

I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists.

Client Responsibility

I acknowledge that I am responsible for all charges for services provided to the client listed above which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan. To the extent no coverage exists under my Health Insurance Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by insurance. I further agree that, if permissible by law, I will reimburse Connect Hearing for all costs, expenses and attorney's fees that may be incurred by Connect Hearing to collect those charges.

Date: _____

Client or Representative Name (please print): _____

Signature: _____

Relationship to Client: _____