NO SHOW AND LATE CANCELLATION POLICY

This policy has been established to help us serve you better and is effective 7/14/2014.

It is necessary for us to make appointments in order to see our patients as efficiently as possible; therefore, we request that if you must cancel your appointment you provide at least 24-hours’ notice. This will enable another person who is waiting for an appointment to be scheduled during that appointment time. NO SHOWs and LATE CANCELLATIONs delay the delivery of care to other scheduled patients. We make every effort to help our patients keep their appointments by calling the day before their appointment to remind them of the time and confirm their attendance.

A NO SHOW is defined as missing a scheduled appointment.

A LATE CANCELLATION is defined as cancelling an appointment without calling 24 hours in advance of the scheduled appointment.

A charge of $50.00 will be assessed for each NO SHOW or LATE CANCELLATION.

We understand that situations arise, occasionally, when an appointment cannot be kept and adequate notice is not possible such as for medical emergencies. These situations will be considered on a case-by-case basis, and fees may be waived with management approval.

Patients who do not appear for their appointment without calling to cancel will be considered a NO SHOW. Patients who NO SHOW two or more times in a 12-month period may be dismissed from the practice and will be denied future appointments.

NO SHOW and CANCELLATION fees are the sole responsibility of the patient.

Our practice firmly believes that a good staff/patient relationship is based upon mutual understanding and open communication. Questions regarding NO SHOW and/or LATE CANCELLATION fees should be directed to Mrs. Tammy Wood, Administrative Coordinator, at 936/632-2252.

Please sign that you have read, understand and agree to this NO SHOW and LATE CANCELLATION Policy.

__________________________________________________________  __________________________
Patient Name (Please Print)     Date of Birth
__________________________________________________________ __________________________
Signature of Patient or Patient Representative   Date
Thank you for choosing AUDIOLOGICAL SERVICES as your hearing health care provider. AUDIOLOGICAL SERVICES is committed to providing professional, quality, hearing health care. Following is a statement of the Financial Policy. All patients are required to read, sign and complete this insurance form before seeing the hearing health care provider. Full Payment Is Due At Time Of Service. Cash, checks, Visa, Master Card or Discover and/or an extended payment plan with prior approved credit are accepted options.

INSURANCE RESPONSIBILITY STATEMENT: Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on various contracts. I understand that insurance is a method for me to receive reimbursement for fees I have paid for services rendered. It is my responsibility to pay the deductible, co-insurance, and other balances not paid by my insurance. I understand that AUDIOLOGICAL SERVICES files insurance forms as a courtesy and gives me an estimate of my insurance coverage. AUDIOLOGICAL SERVICES will assist me in receiving reimbursement as much as possible, but I am responsible for my account.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and instruct my insurance carrier(s) to make payment directly to AUDIOLOGICAL SERVICES for the expense of benefits otherwise payable to me. I understand that I am financially responsible to AUDIOLOGICAL SERVICES for charges incurred. I further assign all right payment due me for services rendered under said policies. This assignment will remain in effect until revoked by me.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that I received a copy of Audiological Services’ Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice is in the reception area and that any revised Notice of Privacy Practices will be made available.

AUTHORIZATION TO RELEASE INFORMATION: I authorize AUDIOLOGICAL SERVICES to release the records relating to my identity and/or other health care information, by telephone in writing or pictorial, to my health care and/or service provider(s). I authorize the release of the same information to insurance carrier(s) and fiscal intermediaries or their representatives for reimbursement or utilization review. Also, I authorize AUDIOLOGICAL SERVICES to share my medical information with _____________________________.

By signing below I represent that all information provided by me is true and that I have read and understand the above paragraphs regarding insurance responsibility, assignment of insurance benefits, acknowledgement of Notice of Privacy Practices and authorization to release information.

PATIENT INFORMATION:

DR / MR / MRS / MS / MISS: ______________________ DATE OF BIRTH: ____/____/____
MAILING ADDRESS: _____________________________ CITY: _______ STATE: _____ ZIP: ______
PHYSICAL ADDRESS: __________________________ CITY: _______ STATE: _____ ZIP: ______
CONTACT PHONE #1: __________________________ HM WK CELL CONTACT PHONE #2: __________ HM WK CELL
CONTACT PHONE #3: __________________________ HM WK CELL CONTACT PHONE #4: __________ HM WK CELL
EMAIL ADDRESS: ______________________________ SKILLED NURSING FACILITY: NO / YES
PARENT’S NAME (IF MINOR): ______________________ SPOUSE/PARTNER NAME: ________________
MARITAL STATUS: Single / Married / Other PATIENT’S SS#: ________________________________
REFERRAL SOURCE: DR TV Newspaper Phone Book Internet Friend (Name): _______________________

INSURANCE INFORMATION

PRIMARY INS. CO: ___________________________ POLICY #: __________ GRP #: ___________
POLICY HOLDER’S NAME: ____________________ POLICY HOLDER’S DOB: ____/____/____
POLICY HOLDER’S EMPLOYER: __________________
PATIENT RELATIONSHIP TO POLICY HOLDER: Self / Spouse / Child / Other

SECONDARY INS. CO: __________________________ POLICY #: __________ GRP #: ___________
POLICY HOLDER’S NAME: ____________________ POLICY HOLDER’S DOB: ____/____/____
POLICY HOLDER’S EMPLOYER: __________________
PATIENT RELATIONSHIP TO POLICY HOLDER: Self / Spouse / Child / Other
IS THERE OTHER INSURANCE THAT MAY PAY FOR SERVICES? YES / NO

_________________________________________  _________________________________________
Signature of Patient/Responsible Individual Date  Signature of Witness Date
HEARING CASE HISTORY

NAME: ________________________________ DOB: ___/___/______ AGE: ______ Sex: M/F DATE: __________

REFERRING PROFESSIONAL: ________________________________ CURRENT COMPLAINT/DIAGNOSIS: ________________________________

PLEASE CIRCLE THE TREATMENT RECEIVED FOR CURRENT COMPLAINT? None Medication Surgery Aural Rehabilitation

PLEASE CIRCLE ANY OF THE FOLLOWING PROCEDURES PERFORMED FOR CURRENT COMPLAINT:

CT SCAN WHEN? ___/___/______ RESULTS? ________________________________

MRI WHEN? ___/___/______ RESULTS? ________________________________

ENG (Balance/Dizziness Testing) WHEN? ___/___/______ RESULTS? ________________________________

X-RAYS WHEN? ___/___/______ RESULTS? ________________________________

ARE YOU CURRENTLY PREGNANT? (Circle One) NO YES WHICH TRIMESTER? (Circle One) First Second Third

PLEASE PROVIDE A LIST ANY MEDICATION(S) / HERBS TAKEN REGULARLY AND FOR WHAT CONDITION(S): __________________________________________________________

HAVE YOU EVER BEEN GIVEN DRUGS THAT YOU WERE TOLD MIGHT AFFECT YOUR HEARING/BALANCE? (Circle One) NO YES

PLEASE CIRCLE ANY OF THE FOLLOWING CURRENT OR HISTORICAL MEDICAL CONDITIONS THAT APPLY:

CARDIOVASCULAR ATHEROSCLEROSIS / HEART ATTACK / HEART DISEASE / HYPERTENSION / STROKE EAR DEFORMITY R / L

ENDOCRINE: DIABETES MELLITUS: (Circle One) JUVENILE / ADULT ONSET THYROID DISEASE YEAR OF DIAGNOSIS? __________

GASTROINTESTINAL DIVERTICULOSIS / GERD / IBS / LIVER DISEASE HEMATOLOGIC/LYMPHATIC ANEMIA / LYMPHOMA / LEUKEMIA

IMMUNOLOGIC AIDS GENITOURINARY KIDNEY DISEASE MUSCULOSKELETAL ARTHRITIS / FIBROMYALGIA / GOUT / TENDINITIS

NEUROLOGICAL FASCIAL WEAKNESS / FREQUENT HEADACHES / MENINGITIS / NEUROPATHY / SEIZURES

PSYCHIATRIC ADD / ADHD / ALZHEIMER’S / ANXIETY / AUTISM / DEPRESSION / OCD / PTS / SCHIZOPHRENIA

RESPIRATORY ASThma / COPD / EMPHYSEMA / PNEUMONIA / SLEEP APNEA / UPPER RESPIRATORY INFECTION

CANCER: YEAR OF DIAGNOSIS? __________ LOCATION IN BODY? ________________________________

TREATMENT? ________________________________

HEAD INJURY? NO / YES CAUSE? ________________________________ WHEN? __________ LOST CONSCIOUSNESS? NO / YES AFFECTED HEARING? NO / YES

DID INJURY CAUSE? CONCUSSION DIZZINESS SKULL FRACTURE TINNITUS VERTEBRAL FRACTURE WHIPLASH

OTHER MAJOR DISEASES, ILLNESSES, INJURIES OR ACCIDENTS? __________________________________________________________

PLEASE COMPLETE THE FOLLOWING SOCIAL BEHAVIORS THAT APPLY:

MILITARY HISTORY ________________________________ RECREATIONAL HISTORY ________________________________ OCCUPATION ________________________________ RETIRED? NO / YES

ALCOHOL USE ________________________________ CAFFEINE USE ________________________________

GENERAL STRESS LEVEL ________________________________ TOBACCO: SMOKING _______ SMOKELESS ______

CIRCLE IF EXPOSED TO: TOXIC CHEMICALS ORGANIC SOLVENTS ASPHYXIANT GASES HEAVY METALS

PLEASE LIST ANY OF THE ABOVE: __________________________________________________________

EXCESSIVE NOISE EXPOSURE? CONSTRUCTION ENGINES (AUTO / BOAT / MOTORCYCLE / SKIMOBILE) EXPLOSIONS FACTORY FARMING

FIRE / POLICE DEPARTMENTS FOUNDRY GUNFIRE (MILITARY / OCCUPATIONAL / RECREATIONAL) HEAVY EQUIPMENT LOGGING / LUMBER INDUSTRY

MINING POWER TOOLS PRINTING LOUD MUSIC (AMPLIFIED / LIVE) TRANSPORTATION AIRPLANE / BOAT / TRAIN / TRUCK

OTHER? ________________________________ DURATION? __________ WHEN? __________

PLEASE CIRCLE ANY OF THE FOLLOWING CURRENT OR HISTORICAL OTOLARYNGOLOGICAL MEDICAL CONDITIONS THAT APPLY:

ALLERGIES / BELL’S PALSY / CHOLESTEATOMA / EAR FULLNESS / EAR PAIN / EAR PRESSURE / FACIAL PAIN / NUMBNESS / PARALYSIS

LABYRINTHITIS / MASTOIDITIS / OTOSCLEROSIS / SINUSITIS / OTHER? ________________________________

HAVE YOU HAD ANY PROBLEMS WITH YOUR JAW OR YOUR TEETH? CLICKING GRINDING INJURY MISALIGNMENT PAIN SURGERY

EARWAX PROFESSIONALLY REMOVED: HOW OFTEN? ________________________________ BY WHOM? ________________________________
**ADDITIONAL PERTINENT INFORMATION**

**DO** have you been diagnosed with any of the following?  

- **FAMILY** VERTIGO  
- **TINNITUS**  
- **HEARING LOSS**

**PREVIOUS HEARING EVALUATION:**  

- **HEARING LOSS:**  
  - **Location:** 
  - **Year:** 
  - **Results:** 
  - **When did you first notice a change in your hearing?** 
  - **Did you experience illness, accident, other incident?** 
  - **Do you have difficulty understanding speech?**  
    - **In quiet**  
    - **In noise**  
    - **When using the cell or telephone**

- **TINNITUS:**  
  - **Constant,** **Frequent,** **Occasional**  
  - **Sounds like:** 
  - **How long?**

- **Vertigo:**  
  - **BPPV**  
  - **Light-headedness**  
  - **Active,** **Inactive Meniere’s Disease**  
  - **Rotary**  
  - **Nausea**

**Vertigo**

<table>
<thead>
<tr>
<th>How often?</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of onset?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Do you know what triggers your episodes?</td>
<td>No / Yes</td>
<td>Explain</td>
<td></td>
<td></td>
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</tbody>
</table>

**Family History of Hearing Loss, Dizziness, Ear Surgery, Hearing Aids, Kidney Disease?**  

- **Have you been diagnosed with any of the following?**  
  - **Chicken Pox**  
  - **Diphtheria**  
  - **German Measles (3-day, Rubella)**  
  - **Hepatitis**  
  - **Malaria**  
  - **Measles**  
  - **Mononucleosis**  
  - **Mumps**  
  - **Rheumatic Fever**  
  - **Scarlet Fever**  
  - **Syphilis**  
  - **Tuberculosis**  
  - **Whooping Cough**  
  - **Other Communicable Disease**

**Do you own a hearing aid(s)?**  

- **No / Yes**

**Ear(s) fit?**  

- **R / L**

**Do you wear a hearing aid(s)?**  

- **No / Yes**

**Type:**  

- **Analog / Programmable / Digital**

**Style:**  

- **B/C**  
- **mBTE**  
- **BTE**  
- **mRITE**  
- **RITE**  
- **CROS**  
- **ITE**  
- **HS**  
- **ITC**  
- **MC**  
- **CIC**  
- **IIC**  
- **Cochlear Implant**

**Year of first fitting:**

**Assessment of current aid(s):**

**Additional pertinent information:**