DALLAS EAR INSTITUTE

THE HEARING CENTER
DALLAS EAR INSTITUTE

7777 FOREST LN #A103 / #A107
DALLAS, TX 75230

REGISTRATION Today's Date: _____

Last Name: _____ First Name: _____ Middle: _____

Birthdate: _____ Age: _____ Gender: M F Social Security #: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Pharmacy Name, Location and Phone:

RESPONSIBLE PARTY INFORMATION: (POLICY HOLDER) – IF SAME AS PATIENT CAN SKIP THIS SECTION

Last Name: _____ First Name: _____ Middle: _____

Relationship to Patient: _____ Birthdate: _____

Age: _____ Gender: M F Social Security #: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

WHO TO CONTACT: I hereby give permission to Dallas Ear Institute to disclose and discuss any information related to my medical condition, appointments, and records to/with the following:

Name: _____Relationship:_____ Phone: _____

Name: _____Relationship:_____ Phone: _____

Preferred Methods of Contact (circle): Home Phone Work Phone Cell Phone Email Text

May we leave a voicemail with detailed information? Yes No

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require specific authorization prior to any disclosure of any medical information.

_____ _____

Printed Name of Patient or Legal Representative Date

_____

Signature of Patient of Legal Representative

PLEASE PROVIDE US WITH ALL OF YOUR INSURANCE CARDS (INCLUDING MEDICARE) AND DRIVER'S LICENSE SO THAT WE MAY MAKE A COPY FOR YOUR FILE. I hereby authorize the release of any medical information in the processing of my claim. I also authorize payment directly to Dr. Peters, Dr. Hahn, and Dr. Dansby for the medical/surgical benefits.

_____ _____

Signature of Patient/Representative Relationship to Patient (if applicable)

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT FORM

I acknowledge receipt of this Notice of Privacy Practices which I have reviewed and give my permission to Dallas Ear Institute to use and disclose my health information in accordance with it.

_____ _____

Signature of Patient/Representative Relationship to Patient (if applicable)

_____ _____

Printed Name of Patient Date

CASE HISTORY

Name: _____ Date: _____

Age: _____ DOB: _____Gender: M F Occupation: _____

Primary reason for visit?

_____

Primary Care Physician: Last: _____First:_____Location:_____

Who may we thank for referring you?

_____

MEDICATIONS: Which of the following types of medications have you taken? (Indicate dosage and length of time taking)

Name Amount How Often

_____

_____

_____

_____

_____

_____

ALLERGIES: Are you allergic to any medications? YES NO

If so, which ones: _____

What type of reaction? _____

PAST MEDICAL HISTORY: (circle all that apply)

General	None	Weight Change / Fatigue / Difficulty Walking
Eyes	None	Glaucoma / Cataracts / Double Vision
Heart	None	High Cholesterol/Hypertension/Heart Attack/Cardiac Disease
Lung	None	Asthma / Snoring / Sleep Apnea / COPD
Gastro Intestinal	None	Ulcers / Reflux Disease / Hepatitis
Kidney	None	Stones / Renal Failure / Prostate / UTI
Musculo Skeletal	None	Arthritis / Fractures / Weakness / TMJ
Endocrine	None	Thyroid / Diabetes
Neurological	None	Migraines / Head Trauma / Stroke / Multiple Sclerosis
Immunodeficiency	None	Seasonal Allergies / Autoimmune / Sinusitis / HIV
Psychiatric	None	Depression / Anxiety / Psychosis
Other		

SURGICAL HISTORY: (including ear surgery): Include type of surgery and date of procedure.

_____

_____

_____

_____

FAMILY HISTORY: What medical problems run in your family (including hearing loss)?

Father: _____

Mother: _____

Other: _____

SOCIAL HISTORY:

Do you smoke? Yes No How many cigarettes per day? _____

Do you drink alcohol? Yes No If yes, _____ Occasional _____ Moderate _____ Frequent

Do you drink caffeine? Yes No

PRESENT PROBLEM:

	Right Ear	Left Ear	Duration
Hearing Loss	_____	_____	_____
Fluctuating Hearing	_____	_____	_____
Ear Fullness	_____	_____	_____
Ringing/ Tinnitus	_____	_____	_____
Ear Infection	_____	_____	_____
Better Hearing Ear	_____	_____	_____
Hearing Aid	_____	_____	_____
Ear Pain	_____	_____	_____

Do you have dizziness? YES NO (If no, skip this section)

If yes, when did it begin? _____

How long does it last? _____

How often does it happen? _____

Is your dizziness: MILD MODERATE SEVERE

I ACKNOWLEDGE THAT THE INFORMATION STATED ABOVE IS TRUE AND COMPLETE:

_____	_____	_____
Printed Name	Patient/Guardian Signature	Date

DALLAS EAR INSTITUTE

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bills is considered a part of your treatment. The following is a statement of our financial policy, which we require you to read, agree to and sign prior to any treatment. Dr. Peters, Dr. Hahn and Dr. Dansby render only services that, in their best professional judgment, is needed to provide quality medical care for you.

PAYMENT IS DUE AT THE TIME OF SERVICE

We accept cash, checks, Visa, MasterCard, American Express

REGARDING INSURANCE

Our office is pleased to assist you in filing claims with your insurance company for reimbursement of these expenses. We will wait 45 days for your insurance company to pay your claim and if they do not we will give you 30 days to pay the balance. If your account becomes outstanding, it will be sent to a collection agency and 40% will be added to the balance.

- ***The patient is responsible to pay any deductible and co-payments at the time services are rendered.***
- ***It is your responsibility to know if a referral is necessary for your visit and obtain prior to your appointment if needed. If a referral is required and not present at the time of your visit, you may choose to see the doctor and pay for your visit at that time or reschedule once the referral is obtained.***
- ***Any portion of a billed amount that is labeled "disallowed" or "not covered" will become the patient's responsibility.***
- ***Our office NEVER guarantees that your insurance will pay. We will make every attempt at the beginning of your health care to receive verification of your policy benefits. However, if for some reason your insurance claim is denied, you are responsible for the amount due on your account.***
- ***Your insurance is a contract between you, your employer, if a group policy, and the insurance company. We are not a party to that contract. While we have an agreement with the Health Plan to provide services, any questions regarding coverage must be resolved by you with the insurance company.***
- ***Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.***

USUAL AND CUSTOMARY RATES: ***Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary.***

CHARGES FOR EQUIPMENT/HEARING DEVICES: **The total cost of equipment is due at the time the equipment is fitted/received. You will be reimbursed any amount covered by your insurance. However any portion of the device(s) or equipment that is not paid by insurance ("disallowed", "not covered", "provider discount", etc.) will become your responsibility.**

NSF CHECKS: ***All returned checks will be assessed a $36.00 fee. All returned checks not paid in 15 days will be filed with the proper authorities.***

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read, understand and agree to the provisions of this financial policy.

Signature of patient or person responsible for the bill ***Date***

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THIS IS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA).
PLEASE REVIEW IT CAREFULLY.

Dallas Ear Institute is committed to maintaining the privacy of your health information and has therefore adopted the following privacy policies.

Uses and Disclosures of your Protected Health Information not requiring your consent.

Treatment: Your health information may be used by the staff of Dallas Ear Institute and/or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing your medical conditions, and providing the necessary medical treatment. For example, results of laboratory testing and/or our treatment of your medical conditions will be available in your medical records to any healthcare professional who may provide treatment.

Payment: Your health information may be used to obtain payment from your health plan, credit card companies that you may use to pay for services, or from other sources of payment such as a collections agency. For example, in an effort to get payment from your health plan, they may request and receive information on dates of service, services provided, and medical conditions being treated.

Healthcare Operations: Your protected health information may be used to support the day-today activities of Dallas Ear Institute. For example, we may use your diagnosis, treatment, and outcome information to measure the quality of the services we provided or to assess how effective our treatment was when compared to our other patients in similar situations.

Legal Authorities: In some situations, our staff may be required to disclose your health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we are required by law to report abuse, neglect, domestic violence, or certain physical injuries.

Public Health Officials: Your health information may be disclosed to public health agencies that are authorized by law. For example, all healthcare professionals are required to report certain communicable diseases to the State Health Department.

Additional uses that do not require your consent.

Correspondence: Your health information will be used by the staff of Dallas Ear Institute to remind you of upcoming appointments. We may also send you information about goods available for treatment of your medical condition that we feel you may find to be of interest.

Activities related to death: Your health information may be disclosed to a coroner or medical examiner for the purpose of completing a death certificate or investigating a death.

Worker's Compensation: If applicable, your health information may be shared for any Worker's Compensation claim that is reasonably related to any injury.
Any other use or disclosure of your protected health information will REQUIRE WRITTEN AUTHORIZATION. (If necessary, please ask the receptionist for the appropriate form).

Dallas Ear Institute will make every effort to maintain the privacy of your health information. We are required by law to not only provide you with this notice of privacy practices, but to abide by the content outlined in this notice.

Your rights regarding your protected health information.

1. the right to request restrictions on the use and disclosure of your health information;
2. the right to receive confidential communications among our staff related to your medical conditions and treatment;
3. the right to review and copy your health information, with the exception of psychotherapy notes;
4. the right to make changes to your health records
5. the right to receive a written listing of how, to whom, and why your protected health information has been disclosed since April 14, 2003;
6. the right to request and receive a printed copy of this notice.

Our rights regarding your health information

1. As permitted by law, Dallas Ear Institute reserves the right to amend or modify our privacy policies and practices. Such changes may be required by federal and state regulations, and we will provide you with a revised notice on your next office visit.
2. Dallas Ear Institute reserves the right to require written request from you to inspect or copy your health information.

If you feel like your privacy rights have been violated or you would like to submit a comment, please do so by sending a letter to:

Executive Director
Dallas Ear Institute
7777 Forest Lane, Ste. A-103
Dallas, TX 75230