

Welcome to Our Practice (Child)

Please fill in these forms to the best of your ability

Patient Name _____ Date of Birth (M/D/Y) ___/___/___ Age ___ Male ___ Female ___

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Alternate Phone _____

Primary Insurance Type: _____ ID: _____ Group: _____

Secondary Insurance Type: _____ ID: _____ Group: _____

If patient is a student, name of school: _____ City _____ State _____

Parent's Name _____ Employer _____ Work Phone _____

Emergency Contact: _____ Relationship _____ Phone _____

Whom may we thank for referring you? _____ Receive Key Hearing newsletter? Y / N

Who is the referring physician? _____ Phone _____
(If different from above)

Who is your primary care physician? _____ Phone _____

Release of Medical Information To Providers

Today's visit results will be faxed to your referring provider. If you would like records forwarded to another provider please provide that information below:

I, _____, hereby authorize Key Hearing to release any and all medical information in the course of my (or my child's) treatment to the primary care physician listed above.

I would also like to have this information forwarded to: _____

Patient/Parent/Guardian Signature

_____/_____/_____
Date

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____

Date of Birth (M/D/Y): ___ / ___ / ____

Previous Name (if applicable): _____

This release of information allows us to share your healthcare information to the friend / family member below on your behalf if ever necessary:

I request and authorize Key Hearing to release healthcare information of the patient named above to the following friend / family member on my behalf if ever necessary:	Name: _____
	Address: _____
	City, State & Zip: _____
	Relationship: _____

This Request and Authorization Applies to:

All healthcare information

Healthcare information relating to the following treatments, conditions or dates:

Other (Please Specify):

Additional Information to be Released

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum (LGV), HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____	Today's Date (M/D/Y): ___ / ___ / ____
--------------------------	--

Child Case History Form

Name: _____

Date: _____

Age: _____

For what reason was this hearing test arranged?

Is your Child on any medications?

Yes No

If so, what and what for? _____

Has your child ever had a hearing test before?

Yes No

If so, when and where? _____

Do you have any concerns about your child's hearing?

Yes No

Does your child seem to hear better on some days than others?

Yes No

Does anyone in your family have hearing problems?

Yes No

Were any of the following present after your child's birth or during the first two months?

- | | | |
|--|--|---|
| <input type="checkbox"/> Prematurity | <input type="checkbox"/> Appeared Yellow | <input type="checkbox"/> Poor weight gain |
| <input type="checkbox"/> Stayed in Hospital after mother went home | <input type="checkbox"/> Was in incubator | <input type="checkbox"/> Infections at birth |
| <input type="checkbox"/> Did not pass hearing screening at birth | <input type="checkbox"/> Physical deformities | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> High fever | <input type="checkbox"/> Birth weight less than 5 lbs. | |

Does your child turn toward sound? Yes No

Has your child had ear infections? Yes No How Many? ____

ASSIGNMENT RELEASE AND FINANCIAL AGREEMENT

It is very important for you to know your insurance deductible and percent patient responsibility. You should review your insurance coverage or call your insurance company to review this information.

Problems related to your hearing and balance requires special attention. Diagnostic studies are performed through our office and these include VNG (ENG) and hearing tests. Additionally, we may perform procedures such as ear cleaning.

When you receive a statement from your insurance company describing a procedure/diagnostic study, please be advised that this refers to an "in office" procedure or diagnostic study performed during your **office visit**. Depending on your insurance plan, these charges may be applied to your deductible. (It is important for you to know your insurance deductible and percentage responsibility.)

Assignment Release and Financial Agreement

I hereby authorize treatment and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of services and I am financially responsible for non-covered services. I authorize the medical provider to release any information requested. I understand that my insurance may deny payment for any reason including, but not limited to the following services: services not provided by my primary care provider and services not authorized or covered by my insurance company. If the primary care physician does not provide the referral in cases where it's required, then the specialist visit may not be covered.

I acknowledge that failure to meet my financial obligations may result in referral of my account to a collection agency.

Parent Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES —ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Leah Keylard.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient / Parent or legally authorized individual signature

Date

Printed name if signed on behalf of the patient
(parent, legal guardian, personal representative)

Relationship

This form will be retained in your medical record.

Last Update: 9/27/2017