KEY HEARING
4300 Talbot Road S. Suite 313 Renton WA 98055
425-277-9521 voice / 425-277-9522 fax

Welcome to Our Practice (Adult)

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 _____ Mobile Phone _____ Email Address _____

Work Phone _____ Alternate Phone _____

For appointment reminders and quality control reasons, please contact me via: Email ☐ Mobile SMS ☐ Home Phone ☐

Primary Insurance Type: _____ ID: _____ Group: _____

Secondary Insurance Type: _____ ID: _____ Group: _____

Check Appropriate Employment Status: Full time ☐ Part time ☐ Self ☐ Retired ☐ Active Military ☐ Not Employed ☐

Patient's or Spouse's Employer _____

Business Address _____ City_____ State_____ Zip_____

If patient is a student, name of school/college _____ City _____State _____

Please Check Appropriate Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

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 with be faxed to your referring provider. If you would like records forwarded to another provider please provider 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

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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): ___ / ___ / _____

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Adult Case History Form

Patient Name:_____ Age:_____ Date:_____

1. Chief complaint: □ Hearing Loss (□ Right ear/ □ Left ear) □ Tinnitus/Ringing □ Dizziness
   □ Difficulty hearing (□ in Quiet / □ in Noise) □ Telephone (□ Right ear/ □ Left ear)

2. How long have you noticed this difficulty? _____

3. Is this problem due to a work-related injury/exposure? ☐ Yes ☐ No
   If so: Date of Injury: _____ Explain: _____

4. Do you feel your hearing is changing? ☐ Yes ☐ No (☐ Gradual ☐ Sudden)

5. Have you ever been exposed to loud noise, either recently or in the past? ☐ Yes ☐ No
   If so, please mark all that apply:
   ☐ Farm Machinery ☐ Music ☐ Hunting/Shooting ☐ Factory Noise
   ☐ Power Tools ☐ Military ☐ Jet Engines ☐ Other: _____

6. Have you seen an Ear, Nose and Throat Physician? ☐ Yes ☐ No
   If so, who did you see?_____ When? _____

7. Have you ever had surgery that may have affected your hearing? ☐ Yes ☐ No

8. Is there a history of hearing loss in your family? ☐ Yes ☐ No - If so, who?_____

9. Have you ever had an ear infection? ☐ Yes ☐ No (If Yes, ☐ As a Child and/or ☐ As an adult)

10. Have you, in the past 10 years, experienced chronic or acute dizziness, lightheadedness, or vertigo? ☐ Yes ☐ No
    If Yes, please describe: _____

11. Do you take any prescription medications on a regular basis? Please list:
Medication: _____ For: _____
Medication: _____ For: _____
Medication: _____ For: _____
Medication: _____ For: _____

12. Please check any of the following that you currently have or have had in the past:

☐ Arthritis	☐ Heart Trouble	☐ Measles	☐ Parkinson's
☐ Asthma	☐ Hepatitis	☐ Meningitis	☐ Scarlet Fever
☐ Bell's Palsy	☐ High Blood Pressure	☐ Mumps	☐ Sinusitis
☐ Diabetes	☐ HIV	☐ Neurological Symptoms	☐ Stroke/TIA
☐ Head Injury	☐ Malaria	☐ Visual Trouble-Loss/Sight	

13. Please rank the following in order of importance (1-4), if a hearing aid is recommended for you:
    ____ Improved hearing in quiet ____ Improved hearing in noise
    ____ Cosmetic appearance ____ Expense

14. If you are currently using a hearing aid, or have in the past, please answer the following:
    Which ear is/was aided? ☐ Right ☐ Left
    How long have you used a hearing aid? _____
    What would improve your current hearing aid? _____

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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.

Patient Signature_____ 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. Please review it carefully.

Key Hearing PLLC. respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

For treatment:

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For health care operations:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may contact you to raise funds.
- We may use and disclose your information to conduct or arrange for services, including:
  - medical quality review by your health plan;
  - accounting, legal, risk management, and insurance services;
  - audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of Key Hearing, PLLC. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request. But we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice");
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances;
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please contact: Dr. Leah Wilkinson Keylard: (425) 277-9521

Our Responsibilities

We are required to:

- Keep your protected health information private;
- Give you this Notice;

- Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office to pick one up.

To Ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may *contact* Dr. Leah Wilkinson Keylard, Privacy Officer: (425) 277-9521

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to Dr. Leah Wilkinson Keylard, at our office. You may also file a complaint with the U.S. Secretary of Health and Human Services.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information

Notification of Family and Others

- Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.

You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

We may use and disclose your protected health information without your authorization as follows:

- With Medical Researchers—if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- To Funeral Directors/Coroners consistent with applicable law to allow them to carry out their duties.
- To Organ Procurement Organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- To the Food and Drug Administration (FDA) relating to problems with food, supplements, and products.
- To Comply with Workers' Compensation Laws—if you make a workers' compensation claim.
- For Public Health and Safety Purposes as Allowed or Required by Law:
    - to prevent or reduce a serious, immediate threat to the health or safety of a person
    - or the public.
    - to public health or legal authorities
        - to protect public health and safety
        - to prevent or control disease, injury, or disability
        - to report vital statistics such as births or deaths.
- To Report Suspected Abuse or Neglect to public authorities.
- To Correctional Institutions if you are in jail or prison, as necessary for your health and the health and safety of others.
- For Law Enforcement Purposes such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- For Health and Safety Oversight Activities. For example, we may share health information with the Department of Health.
- For Disaster Relief Purposes. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- For Work-Related Conditions That Could Affect Employee Health. For example, an employer may ask us to assess health risks on a job site.
- To the Military Authorities of U.S. and Foreign Military Personnel. For example, the law may require us to provide information necessary to a military mission.
- In the Course of Judicial/Administrative Proceedings at your request, or as directed by a subpoena or court order.
- For Specialized Government Functions. For example, we may share information for national security purposes.

Other Uses and Disclosures of Protected Health Information

- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

Web Site

- We have a Web site that provides information about us. For your benefit, this Notice is on the Web site at this address: www.keyhearing.com

Effective Date
January 1, 2017

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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 Dr. Leah Wilkinson 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 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