clarity

PATIENT INFORMATION FORM

Date

PATIENT INFORMATION

Patient's Last Name | Patient's First Name | Patient's Middle Name | Suffix | Preferred name

Date of Birth

☐ Male ☐ Female

Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Another _____

Race: ☐ Caucasian (White) ☐ American Indian ☐ African American (Black) ☐Hispanic ☐ Asian ☐ Multiracial ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Refused/Declined Primary Language: _____

Home address: _____ City: _____ State: _____ Zip: _____

Mail to address: _____ City: _____ State: _____ Zip: _____
(If different from home address)

Home Phone: ( ) _____ ☐ This is the primary number for patient.

Cellphone: ( ) _____ ☐ This is the primary number for patient.

Primary Email Address: _____

EMERGENCY CONTACT (Pediatric Patients, please list someone other than parents/guardians)

Name: _____ Home Phone: ( ) _____ Relation to Patient: _____

PARENT/GUARDIAN INFORMATION (Pediatric patients only)

Parent/Guardian 1 (If the address and/or phone numbers are the same as patient, please indicate same.)

Name: _____ _____ _____ _____
Last | First | Middle | Nickname

Date of birth: _____ Home Phone: ( ) _____ Cell Phone: ( ) _____
Month/Day/Year

Home address: _____ City: _____ State: _____ Zip: _____
(If different from the patient)

Employer: _____ Work Phone: ( ) _____ Ext.

Parent/Guardian 2 (If the address and/or phone numbers are the same as patient, please indicate same.)

Name: _____ _____ _____ _____
Last | First | Middle | Nickname

Date of birth: _____ Home Phone: ( ) _____ Cell Phone: ( ) _____
Month/Day/Year

Home address: _____ City: _____ State: _____ Zip: _____
(If different from the patient)

Employer: Work Phone: ( ) Ext.

RESPONSIBLE PARTY

The Responsible Party is the person who is financially responsible for the patient's account and who will receive all account statements to their address.

Last Name | First Name | Middle Name | Relation to Patient

Home Phone: ( ) _____ Cell Phone: ( ) _____
(If different from the patient) (If different from the patient)

Mail to address: _____ City: _____ State: _____ Zip: _____
(If different from the patient)

Social Security Number:

THIS IS A TWO PAGE FORM

Clarity, Inc. | 29 North Academy Street | Greenville, SC 29601 | PH: 864-331-1400 | FAX: 864-331-1416

Patient Name: _____ (Last) _____ (First) _____ (Middle) Date of Birth: _____ (Month/Day/Year)

☐ **Check here if no insurance. Skip to authorizations (below).**

PRIMARY INSURANCE INFORMATON (Please present insurance card and ID to Business Office)

Subscriber: This is the person who carries the insurance. If the subscriber is the patient, skip to insurance co. name field.

Subscriber's name on card: _____ Subscriber's date of birth: _____ (Month/Day/Year)

Patient relationship to subscriber: _____

If address and phone number is same as patient, please indicate same.

Address: _____ City, State, ZIP: _____ Home Phone: ( )

Insurance co. name: _____ Phone: _____

Policy/Cert #: Group no.: Effective Date:

SECONDARY INSURANCE INFORMATON (Please present insurance card and ID to Business Office)

Subscriber: This is the person who carries the insurance. If the subscriber is the patient, skip to insurance co. name field.

Subscriber's name on card: _____ Subscriber's date of birth: _____ (Month/Day/Year)

Patient relationship to subscriber: _____

If address and phone number is same as patient, please indicate same.

Address: _____ City, State, ZIP: _____ Home Phone: ( )

Insurance co. name: _____ Phone: _____

Policy/Cert #: Group no.: Effective Date:

AUTHORIZATIONS

I authorize evaluation and treatment and I authorize release of information for insurance/medical purposes concerning evaluation and/or treatment serivces provided to me by Clarity, Inc. I hereby also authorize payment from my insurance company to Clarity, Inc. for services rendered. In addition, I authorize audio recording for the purpose of accurate scoring during the provision of evaluation services.

Signature _____ Relation to Patient _____ Date _____

ACCEPTANCE OF PAYMENT POLICIES AND FINANCIAL RESPONSIBILITY

I understand that some services provided by Clarity, Inc. may not be covered by my insurance and that I will be responsible for any amount not covered by my insurance at the time of service. I understand that it is my responsibility to notify Clarity, Inc. if my insuranve coverage changes and that I will be financially responsible for any noncovered services. I understand that Clarity, Inc. will collect all applicable copays, deductibles, coinsurance, and fees for services not covered by my insurance at the time services are rendered.

If a deposit is required for scheduled services I understand that if I cancel the appointment(s) within (2) weeks of the appointment(s) and choose not to reschedule the appointment(s), the deposit will be forfeited. This policy does not apply to appointments that must be rescheduled due to illness or family emergency. I further acknowledge that only one reschedule will be allowed before my deposit is forfeited (this does not apply if Clarity, Inc. has to reschedule the appointment).

Signature _____ Relation to Patient _____ Date _____

LATE CANCELLATION AND NO-SHOW POLICY

*I understand that if for any reason I am unable to keep a scheduled appointment, I must contact Clarity at least 24 hours in advance at **(864) 331-1400** to cancel or reschedule. If **two** appointments (in any six-month period) are missed or cancelled with less than 24 hours' notice, Clarity will reschedule the appointment **after** a six-month waiting period from the time of the missed appointment.*

Signature _____ Relation to Patient _____ Date _____

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Privacy Practices and Authorization for Disclosure of Medical Information

The privacy of your medical information is important. We will only share information about the services you receive at Clarity, Inc. with person(s) you designate and via the mean(s) you specify. This authorization shall be in enforce for six years, until the patient reaches the age of majority (18 years of age) or until this authorization is revoked by the patient or the patient's personal representative.

Patient Name: _____ (Last) _____ (First) _____ (Middle) Date of Birth: _____ (Month/Day/Year)

PATIENT'S VERIFICATION CODE

Clarity, Inc. will verify the identity of a person requesting protected health information. Please provide a word/phrase that Clarity, Inc. can ask for to verify identity: _____

SHARING INFORMATION WITH OTHERS

Please CHECK the information below that you authorize Clarity, Inc. to give out for the above patient, and list who has permission to receive this information other than the patient's parents/legal guardians.

☐ Results of Evaluations ☐ Appointment Information ☐ Billing Information ☐ Treatment Information

_____ Name of person that has permission to receive the above patient information _____ Relationship to Patient

_____ Name of person that has permission to receive the above patient information _____ Relationship to Patient

COMMUNICATION BY PHONE

I authorize Clarity, Inc. to leave a voice message on the phone number below regarding: Check ONLY ONE

☐ All Information including appointments, general information, updates, billing etc.

☐ Appointment information ONLY

( ) _____ Phone Number _____ Relationship to Patient

COMMUNICATION BY EMAIL

Please be aware that email communications can be intercepted during transmission or misdirected. Your use of and authorization for the use of email to communicate Protected Health Information or other information of a confidential nature with Clarity, Inc. indicates that you acknowledge and accept the possible risks associated with such communication. **Please CHECK the information below that you authorize Clarity, Inc. to release about above patient via email and the email address(es) you authorize Clarity, Inc. to send Protected Health Information.**

☐ Results of Evaluations ☐ Appointment Information ☐ Billing Information ☐ Treatment Information

_____ Email Address _____ Name of the account owner for this email address _____ Relationship to Patient

_____ Email Address _____ Name of the account owner for this email address _____ Relationship to Patient

RIGHTS OF THE PATIENT

I understand that I have the right to refuse to sign this Authorization and that my treatment will not be conditioned on signing. I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. Information received by this office is for our own use and will continue to be protected by our Privacy Policy. I understand that I have the right to inspect or obtain a copy of the protected health information disclosed as described in this document. I can do this by written notification to the address below.

I authorize disclosure of the information listed above by the means specified and I have read and received a copy of the Notice of Privacy Practices for Clarity, Inc.

_____ Signature _____ Relation to Patient _____ Date

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HIPAA Notice of Privacy Practices

Effective as of April 14, 2003
Revised November 16, 2018
Contact: (864) 331-1400

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.

This Notice of Privacy Practices is not an authorization. The Notice of Privacy Practices describes, how we our Business Associates and their subcontractors, may use and disclose protected health information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" (also referred to as PHI) is health information is information about you, including demographic information, that may identify you and that relates to your past present, or future physical or mental health care condition and related health care needs.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operation of Clarity, Inc., and any other use required by law.

Treatment- We may use or disclose your protected health information in consultation between health care providers relating to your treatment or for your referral to another health care provider for your treatment.

Payment- We may use or disclose your protected health information for billing, claims management, collection activities, or obtaining payment.

Health Care Operations- We may use or disclose your protected health information for reviewing the competence or qualifications of health care professionals, or for conducting training programs in which students, trainees, or practitioners participate. We may use or disclose your protected health information for accreditation, certification, licensing, or credentialing activities. We may use or disclosure your protected health information to our business associates who participate in our healthcare operations. These disclosures will only be made after we have satisfactory assurances in the form of a Business Associates Agreement from the business associate. These assurances will include their agreement to comply with the HIPAA rules and the compliance of any subcontractor with which they do business. We may use or disclose protected health information to remind you of your appointment, to give you information about treatment alternatives, or other health related benefits or services. If you do not wish to receive appointment reminders or the information about treatment alternatives, other health related benefits, services, you may notify our office and you will receive no further information.

Fundraising- We may contact you for our **own** fundraising activities**.** If you do not want to receive fundraising communication, you may opt-out at any time. Each communication will contain methods to be used to opt-out of further communication. If you opt-out, you will receive no further fundraising communications. If at any time you wish to receive fundraising communication you wish to receive the communication again, you can contact our practice.

USES AND DISCLOSURE THAT REQUIRE YOUR AUTHORIZATION

The following uses or disclosures require a **valid** authorization as defined by the HIPAA standards.

Uses or Disclosures for Psychotherapy Notes- We will require written authorization for most uses and disclosures of psychotherapy notes, where applicable.

Uses or Disclosures for Marketing Purposes- We will require an authorization for uses and disclosures of protected health information used in marketing.

Disclosures for a Sale of Protected Health Information- We will require an authorization for any disclosures that would constitute a sale of protected health information**.**

For any other use or disclosure, you wish us to make, you can give us a written, valid authorization. Your authorization must have specific instructions for the use and disclosure you want us to make. You will have the right to revoke the authorization in writing at any time before the information is used or disclosed.

USES OR DISCLOSURES REQUIRING AN OPPORTUNITY FOR THE INDIVIDUAL TO AGREE OR OBJECT

For disclosures to others involved with your health care or payment, we will inform you in advance and give you the opportunity to agree or object. These disclosures will be limited to the information necessary to help with your health care or payment. These disclosures will only be made if you do not object.

USES AND DISCLOSURES FOR WHICH AN AUTHORIZATION OR OPPORTUNITY TO AGREE OR OBJECT IS NOT REQUIRED

The following uses or disclosures do not require an authorization or the opportunity for you to agree or object.

Uses and disclosures required by law- We may use or disclose protected health information to the extent required by law. The use or disclosure will comply with and be limited to the relevant requirements of such law.

Uses and disclosures for public health activities- We may use or disclose protected health information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, and vital events such as birth or death.

Disclosures about victims of abuse, neglect or domestic violence- We may disclose protected health information about an individual whom We reasonably believes to be a victim of abuse, neglect, or domestic violence.

Uses and disclosures for health oversight activities- We may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations, inspections, licensure, or disciplinary actions.
Disclosures for judicial and administrative proceedings- We may, in response to an order of a court or administrative tribunal, provide only the protected health information expressly authorized by such order or a subpoena.
Disclosures for law enforcement purposes- We may disclose protected health information as required by law including laws that require the reporting of certain types of wounds or other physical injuries.
Uses and disclosures about decedents- We may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may disclose protected health information to a funeral director, as authorized by law, to carry out their duties. This disclosure will be made in reasonable anticipation of death.
Uses and disclosures for cadaveric organ, eye or tissue donation purposes- We may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.
Uses and disclosures for research purposes- We may use or disclose protected health information for research, when the research has been approved by an institutional review board or privacy board, to protect your protected health information.
Uses and disclosures to avert a serious threat to health or safety- We may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, in good faith, if we believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
Uses and disclosures for specialized government- We may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, if the appropriate military authority has published by notice in the Federal Register.
Disclosures for workers' compensation- We may disclose protected health information as authorized by and to the extent necessary, to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

PATIENT RIGHTS UNDER HIPAA

The following information describes your rights under the HIPAA Standards. We require that all requests for the various rights be made in writing and we will provide our decision on your request in writing. You should be aware that there may be some situations when there could be limitations placed on your rights. We are required to permit you to request these rights, but we are not required to agree to your request, **except as in the Right of Restriction section.**
Right of an individual to request a restriction of uses and disclosures- We will permit an individual to request that we restrict uses or disclosures of protected health information about the individual to carry out treatment, payment, or health care operations or to others involved in your care or in payment. We will consider these requests, but we are not required to agree to them, except as discussed in the next section. Under your right of restriction, you may restrict certain disclosures of protected health information to a health plan for payment or healthcare operation, where payment in full is made out of pocket for a healthcare item or service. We will agree to this restriction as long as your payment is honored. If payment is not honored, we are not obligated to continue to abide by the requested restriction.
Confidential communication requirements- We will permit an individual to request and will accommodate reasonable requests to receive communications of protected health information from our practice by alternative means or at an alternative location.
Access of individuals to protected health information- An individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set except as prohibited by state or federal law or certain other exemption. Your access may be provided in electronic form if producible at your request or in another form or format. As permitted by state and federal law, we may charge you a reasonable cost-based fee for a copy of your record. Questions about the fee should be addressed to our Privacy Officer at the phone number listed at the end of this document.
Amendment of protected health information- An individual has the right to ask to have We amend protected health information or a record about the individual in a designated record set for as long as the protected health information is maintained in the designated record set.
Accounting of disclosures of protected health information- An individual has a right to receive an accounting of disclosures of protected health information made by us in the past six years but not before April 14, 2003. The accounting will not include disclosures made for treatment, payment, or operations, as well as authorized disclosures or disclosures made for which you had an opportunity to agree or object. You may receive one free accounting in a 12-month period. There will a reasonable cost-based fee for additional requests.
Right of Breach Notification- An individual has the right to and will receive a notification of any breach of their unsecured protected health information as defined by the Breach Notification Rule. We will fulfill our obligation to provide notice in accordance to HIPAA standards.

COPY OF THIS NOTICE

You have a right to a copy of this notice. Even if you agreed to receive an electronic copy, you may request and receive a paper copy.

OUR DUTIES

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.
We are required to abide by the terms of the notice currently in effect.
We are required to notify you of any change in a privacy practice that is described in the notice to protected health information that we created or received prior to issuing a revised notice. We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. Revised Notices with be available and posted at our office(s) and posted on our web site, if applicable.

COMPLAINTS

If at any time you feel we have violated your HIPAA rights, please contact Clarity's Privacy Officer, 29 North Academy Street, Greenville, SC 29601 or (864) 331-1400, or with the Office of Civil Rights, US Department of Health and Human Services, 61 Forsyth St., SW, Suite 3B70, Atlanta, GA 30323. We will not retaliate against any individual for filing a complaint.

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AUDITORY BRAINSTEM RESPONSE (ABR) AUDIOMETRY

ABR testing is a painless procedure that provides information about the inner ear and brain pathways for hearing. Infants are required to be asleep during the testing, and older children and adults who are in the testing room will need to be quiet and still throughout the procedure. The audiologist will place three to four electrodes on the head and neck of the patient, which will record the brainstem's electrical response to sound.

The sounds used will vary from soft to medium to loud, and will depend on the patient's hearing. The benefit of the ABR is that it can record a response to very soft sounds with varying pitch. The downside is that the audiologists is trying to obtain a very small waveform from the procedure.

For children older than 6 months, please bring their favorite DVD for them to watch during the test if possible. The audiologists may perform other tests at the same time to help determine the presence of, extent, and type of hearing loss, and will review the test results and make recommendations after the test.

For infants under 6 months of age, please come ten minutes early for the appointment, and bring a bottle to feed your baby prior to beginning the evaluation. Please bring a pacifier with you if your child takes one. This appointment will take approximately two hours total.

PLEASE try to keep this appointment if possible! We currently book one month ahead for this appointment. Please call and cancel right away at (864) 331-1400 is you know that you cannot keep the appointment.

We look forward to caring for your child's hearing in the best possible way.

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ADULT
INITIAL QUESTIONNAIRE

Date _____

Patient Name: _____ (Last) _____ (First) _____ (Middle) Date of Birth: _____ (Month/Day/Year)

Questionnaire Completed by: _____ Relation to Patient: _____

REFERRAL INFORMATION

Has the patient been to this agency before? □ No □ Yes If yes, when? _____

Primary Care Physician: _____

Referring provider (if different from primary care physician): _____

Who recommended the patient for this appointment?

What are your reason(s) for seeking services at Clarity, Inc. at this time?

When did the patient (or someone else) first notice these concerns, and what did the patient (or someone else) feel led to/caused these concerns?

FAMILY INFORMATION

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Occupation: _____ Highest Level of Education Completed: _____

What is the patient's primary language? _____
Is this the patient's native language? □ No □ Yes
If no, what is the patient's native language? _____

PERSONAL MEDICAL HISTORY

Did the patient have any serious illnesses, injuries (including head) or medical problems **as a child**? □ No □ Yes
If yes, please state: _____

Has the patient had any serious illnesses, injuries (including head) or medical problems **as an adult**? □ No □ Yes

If yes, please state: _____

Is the patient currently being treated for? □ Diabetes □ Heart Condition □ High Blood Pressure

□ Kidney Disease □ Other _____

Please list any medications the patient is currently taking and the reason for taking each medication:

THIS IS A ONE PAGE FORM

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ADULT
AUDIOLOGY SUPPLEMENT

Date _____

Patient Name: _____ (Last) _____ (First) _____ (Middle) Date of Birth: _____ (Month/Day/Year)

Questionnaire Completed by: _____ Relation to Patient: _____

MEDICAL HISTORY

When were your hearing difficulties first noticed? _____

Did it happen gradually or suddenly? _____

What other symptoms occurred around the same time? _____

Possible causes of hearing loss? _____

Is there a family history of hearing loss? □ No □ Yes
If yes, please describe: _____

Have you been seen by a physician for suspected hearing loss? □ No □ Yes
If yes, please state by whom, any diagnoses and treatments recommended:
_____

Have you had or do you currently have any of the following?

Dizzy spells or loss of balance? □ No □ Yes
If yes, please state when, how often, and describe the dizziness if possible:
_____

Ear infection(s)? □ No □ Yes
If yes, □ Left □ Right □ Both

Ear surgery? □ No □ Yes
If yes, when? _____ By whom? _____

Ear pain? □ No □ Yes
If yes, □ Left □ Right □ Both
When and how often? _____

Ear drainage or running ears? □ No □ Yes
If yes, □ Left □ Right □ Both
When and how often? _____

Do your ears ring, or do you have other head noises? □ No □ Yes
If yes, □ Left □ Right □ Both
When and how often? _____

Do your ears feel full? □ No □ Yes
If yes, □ Left □ Right □ Both

THIS IS A THREE PAGE FORM

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Patient Name: _____ (Last) _____ (First) _____ (Middle) Date of Birth: _____ (Month/Day/Year)

DO YOU EXPERIENCE ANY OF THE FOLLOWING? (Please mark all that apply.)

□ Feel like people mumble?

□ Need the TV louder than other noises?

□ Have trouble understanding conversation?
- □ In quiet from a distance?
- □ In quiet even when near to the speaker?
- □ In background noise?

NOISE EXPOSURE HISTORY

Have you ever worked in a noisy job (including military service)? □ No □ Yes

If yes, what type of job did you do? _____

For how long? _____

Did you use hearing protection (earplugs/ear muffs)? □ No □ Yes

If yes, for how long? _____

Do you or have you ever used guns? □ No □ Yes

If yes, how often? _____

CURRENT FUNCTIONING

How well do you currently hear in the following environments?	Well	Fair	Poor
One-to-one conversations			
Quiet room (1-to-2 people)			
Small group (4-to-6 people)			
Large social gatherings			
In the workplace			
Watching television			
During religious services			
Meetings/lectures			
In the car			
Outdoors			
On the telephone			

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Patient Name: _____ (Last) _____ (First) _____ (Middle) Date of Birth: _____ (Month/Day/Year)

WHAT IS YOUR EXPERIENCE WITH HEARING AIDS? (Please check all that apply.)

□ I have never used or visited a Hearing Health Care Professional to ask about a hearing aid(s).

□ I have been to another Hearing Health Care Professional to gather information regarding my hearing difficulties but have not tried or purchased a hearing aid(s).

□ I have tried a hearing aid(s) but returned the instrument(s).

□ I have a hearing aid(s) but only wear it occasionally or not at all.

□ I have a hearing aid(s) and wear it regularly in the _____ Right Ear and/or _____ Left Ear.

Please rank the following in terms of importance in a hearing aid (1 to 4 with 1 being the <u>most</u> important):

_____ Overal Sound Quality _____ Reliability _____ Style/Appearance _____ Cost

On a scale of 1 to 10, how motivated are you to take action regarding your hearing loss? (Please check one.)

□ 1-2	□ 3-4	□ 5-6	□ 7-8	□ 9-10
Not Motivated	Somewhat Motivated	Motivated	Very Motivated	Extremely Motivated

PLEASE DESCRIBE ANY ADDITIONAL COMMENTS OR CONCERNS (and/or attach relevant documentation):

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