DR. GEISSLER'S HEARING CENTER

Procedure Codes

Patient Name: _____ Date: _____

Comprehensive Audiological Eval	**92557**
Tympanometry	**92567**
Acoustic Reflex	**92568**
Audiometry, air and bone	**92553**
Tympanometry & Acoustic Reflex	**92550**
Tympanometry, Acoustic Reflexes & Decay	**92570**
Otoacoustic Emissions	**92588**

<u>Modifiers</u>

52- Reduced Services

Cerumen Management	**69210**
Consultation	**92591**
N/C Office Visit	**90699**

I recognize and accept full personal responsibility for all professional services rendered and further authorize the insurance company to pay benefits directly to the physician. I authorize the release of any medical information necessary to process this claim. I assign Medicare benefits payable for services and authorize Dr. Geissler's Hearing Center to submit claims on my behalf. I certify that I do not receive Medicaid Benefits.

_____ _____

SIGNATURE **TODAY'S DATE**

DR. GEISSLER'S
HEARING CENTER

10110 Donald Powers Dr., Ste. 202A, Munster, In. 46321
Phone: (219)836-0022

Welcome to Dr. Geissler's Hearing Center, where excellent hearing care is our top priority!
Please tell us a little about yourself by completing this form.

PERSONAL INFORMATION:

PATIENT'S NAME_____
FIRST MIDDLE LAST

MAILING ADDRESS_____
CITY STATE ZIP

PHONE (HOME)_____(CELL)_____ (WORK)_____

BIRTHDATE _____ AGE_____ MALE _____ FEMALE _____NON-BINARY_____

EMAIL ADDRESS: _____

PLEASE CIRCLE PREFERRED METHOD OF CONTACT: PHONE OR EMAIL

PLEASE CIRCLE MARITAL STATUS: SINGLE, MARRIED OR WIDOWED

CURRENTLY EMPLOYED- YES OR NO IF YES WHERE, _____

FULL TIME_____PART TIME_____RETIRED_____SSN_____

FULL NAME& PHONE NUMBER OF PRIMARY CARE PHYSICIAN_____

FULL NAME & PHONE NUMBER OF REFERRING PHYSICIAN_____

EMERGENCY CONTACT NAME & RELATIONSHIP_____

EMERGENCY CONTACT PHONE NUMBER_____

HOW DID YOU HEAR ABOUT US? _____

INSURANCE INFORMATION - PLEASE READ AND SIGN & INITIAL:

DISCLAIMER: As a professional courtesy, we will submit your claim to your insurance provider, but this does not guarantee their payment. You accept responsibility for co-pay, deductibles, or uncovered procedures. If you have a hearing aid benefit, you may be required to pay for your hearing aid upfront. Upon receipt of payment from your insurance company, we will reimburse you for the amount that the insurance company covered/paid. PLEASE INITIAL: _____

IF HEALTH INSURANCE IS NOT IN YOUR NAME; PLEASE PROVIDE THE FOLLOWING INFORMATION:
Insurance cards(s) will be copied for your file

_____
Name of Insured Address

_____
SSN Relationship to Patient

_____
Insured's Date of Birth Insured's Employer

PLEASE READ AND SIGN:

***Privacy Practice Notice*: According to government law, we are required to make available to you a copy of our privacy practice notice. Your signature below acknowledges your receipt of such:**

SIGNATURE_____ DATE_____

I hereby authorize Dr. Geissler's Hearing Center to furnish information to my insurance carrier concerning my illness and treatment, and I hereby assign the practice all payments for services rendered to my dependents or myself. I understand that I am responsible for payment.

SIGNATURE _____DATE_____

MEDICAL:

Do have ringing or other noises in your ear? Right _____Left _____Both _____ Is it constant or intermittent?
Do you have dizziness or vertigo? Yes _____ No _____
DO YOU WANT THE TEST SENT TO YOUR DOCTOR? YES _____ NO _____

HEARING:

Do you think you have a hearing loss? Yes_____No_____
Is there a **genetic** family history of hearing loss? Yes_____No_____
If yes, who: _____
Have you had noise exposure? Yes_____No_____
If yes, from work/military/hobbies, etc., please specify _____
Have you had your hearing tested before? Yes_____No_____ When_____
Do you currently use a hearing aid? Yes_____No____ If yes, How long? _____
Are you satisfied with it? Yes____No____

THINGS YOU WANT THE DOCTOR TO KNOW:

MEDICATION LIST:

MEDICATION	**DOSE**	**FREQUENCY**

DR. GEISSLER'S
HEARING CENTER

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The department of Health and Human Services has established the Health Insurance Portability and Accountability Act (HIPAA). HIPAA has a Privacy Rule to help ensure that personal health information (PHI) is protected for privacy. The Privacy Rule was also created in order to provide a standard for health care providers to obtain their patient's consent for uses and disclosures of PHI for treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal audiology records and will do all we can to secure and protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information about treatment, payment and health care operations, in order to provide health care that is in your best interest. We may have indirect treatment relationships with you (such as hearing aid manufactures that only interact with health care providers and not patients) and may have to disclose PHI for purposes of treatment, payment of health care operations. These entities are most often not required to obtain patient consent.

We also want you to know that we support your full access to your personal audiology records. You may refuse to consent to the use or disclosure of your PHI, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your PHI. IF you choose to give consent in this document, at some future time you may request to refuse disclosure of all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have the right to access your personal audiology records, to review our privacy notice and to request restrictions and revoke consent in writing. If you have any objections to this form, please ask to speak with your HIPAA Compliance Officer.

_____ Date _____
Signature of Patient or Patient Representative

_____ _____
Printed Name of Patient or Patient Representative Relationship to Patient

PRIVACY NOTICE FOR HIPAA COMPLIANCE

We want you to know that all our staff works with your HIPAA Compliance Officer to understand and comply with government rules are regulations regarding HIPAA with particular emphasis on the Privacy Rule.
It is our policy to properly determine appropriate uses of PHI in accordance with government rules, laws and regulations. As part of this plan, we have implemented a Compliance Program with a Compliance Officer that will help us prevent any inappropriate use of your PHI.

If you have any questions, please ask to speak with our HIPAA Compliance Officer.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

MESSAGE AUTHORIZATION

I, _____, have reviewed Dr. Geissler's Hearing Center Notice of Privacy Practices. I am aware that paper copies of the Notice of Privacy Practice are available upon request.

[ ] I authorize Dr. Geissler's Hearing Center to leave personal information/instruction on my answering machine.

[ ] I **DO NOT** authorize Dr. Geissler's Hearing Center to leave personal information/instruction on my answering machine.

[ ] I authorize Dr. Geissler's Hearing Center to leave personal information/instruction, including results of test, and hearing aid information, with:

Name	Relationship	Phone Number

_____ _____

Signature of Patient or Parent if Minor Date

_____

Printed Name of Patient or Parent if Minor

Email _____