

**ASSOCIATED AUDIOLOGISTS, INC.
NOTICE OF RESPONSIBILITY**

Associated Audiologists, Inc. is a participating provider for the following insurance programs:

Advantra
Aetna (*Diagnostic Only*)**
Blue Cross/Blue Shield of Kansas City
Champus/Tri-Care
Cigna Healthcare (*Excluding GWH-Cigna*)
Coventry Healthcare
Freedom Network

Healthcare Preferred
Humana
Kansas Medicaid
& Childrens Mercy Family Health
United HealthCare (*Diagnostic Only*)**
Medicare
Blue Cross/Blue Shield of Kansas

*** Indicates contract for Diagnostic Services only through this health plan. Not currently contracted for hearing aid benefits.*

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING:

I understand that if my insurance is not listed above, I need to make payment, in full, at the time of service. Associated Audiologists, Inc. will file my insurance claim for me; however, this does not guarantee that my insurance will pay in full, and I will be responsible for payment of any remaining balance due.

I understand that if my insurance policy indicates a required co-payment, I am responsible for payment of this amount at the time of service.

If any of the above listed insurance companies do not cover the full allowed amount of services rendered, I understand that it is my responsibility to pay any remaining balance due.

Most insurance companies do not offer benefits for the purchase of hearing aids; however, there are a few that do have hearing aid benefits. **I understand that it is my responsibility to find out whether or not my insurance policy offers benefits for hearing aids. If it is determined that my insurance does offer benefits for hearing aids, I understand that it is my responsibility to notify Associated Audiologists, Inc. PRIOR to the ordering of my hearing aids(s).**

Associated Audiologists, Inc. accepts payment by cash, personal check, money order/cashiers checks, Visa, Mastercard, Discover, and CareCredit. If other arrangements are necessary, I will discuss them with the office staff before I am seen by the audiologists.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE STATEMENT:

Patient/Guardian Signature

Date

ASSOCIATED AUDIOLOGISTS, INC – PATIENT HISTORY

Patient Name: _____ DOB: _____ Date: _____

Primary Concern(s): _____

How or when did your problem first occur? _____

Have any of these concerns been previously evaluated? _____

If so, where/when: _____ Your Occupation: _____

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

- Pacemaker (*please notify your audiologist)
- Vision Loss
- Peripheral Neuropathy
- Diabetes
- High Blood Pressure
- Heart Condition
- Measles and Mumps
- Meningitis
- Migraines
- Ear Infections
- Meniere's disease
- Sinusitis
- CMV
- Multiple Sclerosis
- Family History of Hearing Loss: Who _____
- Head Injury: Date of Injury _____
- HIV or AIDS
- Hepatitis
- Bell's Palsy: Affected Side _____
- Parkinson's Disease
- Stroke/TIA: Affected Side _____
- Neurological Disorders _____
- Ear Trauma: Type _____
- Ear Surgery: Type _____
- Tingling/numbness in face
- MRI or CT-Scan of head: Date _____ Location _____
- Other _____

II. Do you have any of the following symptoms? If applicable, please indicate which ear.

- | | | | |
|---|----------|-----------|------|
| <input type="checkbox"/> Difficulty Hearing | Left Ear | Right Ear | Both |
| <input type="checkbox"/> Ear Pain | Left Ear | Right Ear | Both |
| <input type="checkbox"/> Ear Drainage | Left Ear | Right Ear | Both |
| <input type="checkbox"/> Ear Fullness/Pressure | Left Ear | Right Ear | Both |
| <input type="checkbox"/> Tinnitus (Noise in your ears/head) | Left Ear | Right Ear | Both |
- Describe Sound _____
- Dizziness: Describe: _____

III. Please mark all that apply if you have difficulty hearing.

- Difficulty in Quiet Environments
- Difficulty in Noisy Environments
- Trouble understanding television
- Trouble understanding on the telephone
- Hearing loss began suddenly
- Hearing loss has progressed gradually
- Fluctuations in your hearing

IV. Please answer the following questions if you have tinnitus (noise in your ears).

- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Did your tinnitus begin suddenly? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did any specific incident precipitate the onset of your tinnitus? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does anything make your tinnitus better? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does anything make your tinnitus worse? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is your tinnitus constant? |

V. Please answer the following questions if you have dizziness/vertigo or imbalance.

- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have dizziness/vertigo? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does anything trigger your dizziness/vertigo? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is your dizziness/vertigo constant? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you off balance? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you experienced falls? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a fear of falling? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you currently use an assistive device? |

VI. Do you have a history of exposure to loud noise? Yes No Hearing Protection: Yes No

Please describe noise exposure: _____

VII. Please list all medication you are currently taking, attach an additional page if needed.

- Medication: _____ For: _____ Since: _____
- Medication: _____ For: _____ Since: _____
- Medication: _____ For: _____ Since: _____
- Medication: _____ For: _____ Since: _____

VIII. Please list three areas you would like to address or problems you would like to improve from today's appointment.

- 1 - _____
- 2 - _____
- 3 - _____

Hearing Aid Preferences

If results show that hearing aids would be beneficial, how ready are you to try amplification?
Please rate your readiness on this 1-10 scale.

Not Ready 1 2 3 4 5 6 7 8 9 10 Absolutely Ready

Please rank these factors in order of importance (1 being most important, 4 being least important):

____ Hearing in Quiet ____ Hearing in Noise ____ Hearing Aid Expense ____ Cosmetics

FOR CURRENT HEARING AID USERS ONLY

- Do you wear 1 hearing aid or two? _____ How long have you worn hearing aid(s)? _____
- Make/Model _____ How old are your present hearing aid(s)? _____
- How often do you wear your hearing aid(s)? _____
- What would you want to improve about your current hearing aids? _____