

ASSOCIATED AUDIOLOGISTS, INC.

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING:

NOTICE OF RESPONSIBILITY

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

Medicare	Freedom Network
Railroad Medicare	Humana
AARP Medicare Complete	Medica Select
Aetna	Meritain Health/Aetna
Blue Cross/Blue Shield	Tri-Care
Cigna Healthcare	United Healthcare (excluding Community Plan & Oxford)
First Health	

****Associated Audiologists is NOT in network with most Individual Exchange/Marketplace Plans**

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 lists 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/Cashier's Checks, MasterCard, Visa, Discover, American Express, Apple Pay, Care Credit and Wells Fargo Healthcare Finance existing accounts. If other arrangements are necessary, I will discuss them with the office staff before I am seen by the audiologists.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Click this link to read full Notice of Privacy Practices:

<https://www.hearingyourbest.com/wp-content/uploads/2025/09/Notice-of-Privacy-Practices-Aug-2025-Final.pdf>

I acknowledge that I received a copy of Associated Audiologists, Inc.'s Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

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

Patient/Guardian Signature

Printed Name

Date



Associated Audiologists, Inc. – Adult Case History

Patient Name: _____ DOB: _____ Date: _____

List the outcomes you hope to achieve from today’s appointment: _____

Do you have difficulty hearing? No Both Ears Right Only Left Only
When did you first notice difficulty hearing? _____ Onset was sudden gradual n/a

Do you have tinnitus (ringing/sound in your ears)? No Both Ears Right Only Left Only
How long have you noticed your tinnitus? _____ Onset was sudden gradual n/a
Is the tinnitus bothersome? Yes No Does it pulse with your heartbeat? Yes No
When are you most aware of your tinnitus? _____ The sound is constant intermittent
Describe the sound you hear: _____

Do you have dizziness or imbalance? Yes No Have you fallen in the past 12 months? Yes No
When did your dizziness/imbalance symptoms begin? _____
Does anything trigger these symptoms? _____

Review of Systems and Conditions (please check all current or previous symptoms/conditions):

- Ear, Nose and Throat**
- Sound Sensitivity
- Ear Pain
- Ear Fullness/Pressure
- Ear Infections
- Ear Drainage
- Ear Drum Perforation
- Ear Surgery
- Sinusitis/Seasonal Allergies
- Meniere’s Disease
- Family History of Hearing Loss

- Eyes**
- Vision Loss
- Glaucoma
- Double Vision
- Macular Degeneration

- Musculoskeletal**
- Pain in Back or Neck
- Back or Neck Surgery
- Arthritis

- Cardiovascular**
- High/Low Blood Pressure
- Cardiovascular Surgery
- Pacemaker

- Neurological**
- Facial Numbness or Tingling
- Numbness in Hands or Feet
- Headaches/Migraines
- Seizures
- Tremors
- Head Injury
- Bell’s Palsy
- Multiple Sclerosis
- Parkinson’s Disease
- Alzheimer’s Disease/Dementia
- Stroke/TIA

- Endocrine**
- Diabetes
- Thyroid Disorder
- Hormone Therapy

- Psychiatric**
- Anxiety/Depression
- Memory Loss
- Cognitive Changes
- Other: _____

- Systemic and Other**
- Measles
- Mumps
- Scarlet Fever
- Lyme Disease
- Herpes
- Hepatitis
- HIV/AIDS
- Chicken Pox/Shingles
- Tuberculosis (TB)
- Meningitis
- Auto-Immune Disorder
- Type: _____
- Kidney Disease
- Cancer
- Type: _____
- Treatment: _____
- Sleep Apnea
- Insomnia
- Other Medical Conditions:
- _____
- _____
- _____



Associated Audiologists, Inc. - Tinnitus Handicap Inventory

Patient Name: _____ DOB: _____ Date Completed: _____

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your tinnitus.

Please answer every question for Y=Yes, S=Sometimes or N=No. Please do not skip any questions.

1. Because of your tinnitus, is it difficult for you to concentrate?	Y	S	N
2. Does the loudness of your tinnitus make it difficult for you to hear people?	Y	S	N
3. Does your tinnitus make you angry?	Y	S	N
4. Does your tinnitus make you feel confused?	Y	S	N
5. Because of your tinnitus, do you feel desperate?	Y	S	N
6. Do you complain a great deal about your tinnitus?	Y	S	N
7. Because of your tinnitus, do you have trouble falling to sleep at night?	Y	S	N
8. Do you feel as though you cannot escape your tinnitus?	Y	S	N
9. Does your tinnitus interfere with your ability to enjoy your social activities (such as going out to dinner, to the movies)?	Y	S	N
10. Because of your tinnitus, do you feel frustrated?	Y	S	N
11. Because of your tinnitus, do you feel that you have a terrible disease?	Y	S	N
12. Does your tinnitus make it difficult for you to enjoy life?	Y	S	N
13. Does your tinnitus interfere with your job or household responsibilities?	Y	S	N
14. Because of your tinnitus, do you find that you are often irritable?	Y	S	N
15. Because of your tinnitus, is it difficult for you to read?	Y	S	N
16. Does your tinnitus make you upset?	Y	S	N
17. Do you feel that your tinnitus problem has placed stress on your relationships with members of your family and friends?	Y	S	N
18. Do you find it difficult to focus your attention away from your tinnitus and on other things?	Y	S	N
19. Do you feel that you have no control over your tinnitus?	Y	S	N
20. Because of your tinnitus, do you often feel tired?	Y	S	N
21. Because of your tinnitus, do you feel depressed?	Y	S	N
22. Does your tinnitus make you feel anxious?	Y	S	N
23. Do you feel that you can no longer cope with your tinnitus?	Y	S	N
24. Does your tinnitus get worse when you are under stress?	Y	S	N
25. Does your tinnitus make you feel insecure?	Y	S	N

FOR CLINICIAN USE ONLY

Total Per Column

x4	x2	x0

Total Score

	+		+		=	
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Have you had noise exposure from any of the following:

Recreational (fire arms/hunting, power tools, etc.): Yes No Hearing protection used: Yes No Sometimes
 Occupational (factory, military, farm equipment, etc.): Yes No Hearing protection used: Yes No Sometimes

Previous Evaluations and Testing – If yes, please list location and date:

Hearing Evaluation: _____ ENT Evaluation: _____
 Tinnitus Evaluation: _____ MRI/CT Scan of Head: _____
 Vestibular Evaluation: _____ Other: _____

Have you used tobacco in the past 24 months? Yes No

List all current prescription and over-the-counter medications/supplements, or submit current list.

Name	Reason	Dose	Frequency How Often	Route Oral, Injection, Topical, Etc.	How Long have you taken it? Approx.

Within the past 12 months...[Please indicate: Yes or No]

1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, and/or meals?	Yes	No
2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids or medical care, or from being with people you wanted to be with?	Yes	No
3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	Yes	No
4. Has anyone tried to force you to sign papers or to use your money against your will?	Yes	No
5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	Yes	No

Associated Audiologists, Inc - Hearing Case History

If you have difficulty hearing or understanding, please complete the following questionnaire:

Instructions: Answer Yes, No, or Sometimes for each question. Do not skip a question if you avoid a situation because of a hearing problem. If you use a hearing aid, please answer according to the way you hear with the aid.

	No	Sometimes	Yes
1. Does your hearing cause you to feel embarrassed when you meet new people?	0	2	4
2. Does your hearing cause you to feel frustrated when talking to members of your family?	0	2	4
3. Do you have difficulty hearing or understanding co-workers, clients or customers?	0	2	4
4. Do you feel handicapped by a hearing problem?	0	2	4
5. Does your hearing cause you difficulty when visiting friends, relatives or neighbors?	0	2	4
6. Does your hearing cause you difficulty in theatres, church or public events?	0	2	4
7. Does your hearing cause you to have arguments with family members?	0	2	4
8. Does your hearing cause you difficulty when listening to the TV, radio or talking on the phone?	0	2	4
9. Do you feel that your hearing limits or hampers your personal or social life?	0	2	4
10. Does your hearing cause you difficulty when in a restaurant with relatives, friends or coworkers?	0	2	4
TOTALS:			

If results indicate that amplification would be beneficial, are you motivated to proceed?

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

What are your goals for a hearing aid? Select ALL that apply

Hearing better in noise Hearing aids that are automatic Hearing aids that are rechargeable
Hearing aids that you can't see Hearing aids that are inexpensive Hearing aids that use Bluetooth

Of the following, which one holds the most importance in achieving your goals? Select ONE

Cost Cosmetics Ease of use Changing batteries Durability Other: _____

Current hearing aid users please complete the following:

How long have you worn hearing aid(s)? _____ Do you wear 1 aid or 2? _____

Current hearing aid make/model? _____ How old are current hearing aids? _____

How often do you wear your current hearing aids? _____

What would you improve about your current hearing aids? _____