Solomons Medical Center
14090 H.G. Trueman Road, Suite 1400
Solomons, MD 20688
*Wednesday and Friday by Appt

Calvert Medical Office Building
110 Hospital Road, Suite 204
Prince Frederick, MD 20678
*Monday, Tuesday, and Thursday

(Phone) 410-610-2246 | (Fax) 443-432-3943 | info@freedomhearing.com

Welcome to Freedom Hearing Center. My name is Dr. Rebecca L. Jahed and I have been a licensed audiologist for 22 years and have practiced in the Southern Maryland area for the past 11 years. I look forward to continuing to serve and provide excellent customer service for many years to come.

Freedom Hearing Center is located at the Solomons Medical Center (Urgent Care Center) in the Radiology Suite (Suite 1400) and at the Calvert Medial Office Building (Suite 204). Please sign in at the front desk and let them know that you are scheduled to see the audiologist.

Please bring the following with you:

1. Completed case history, including your list of current medications
2. Physician referral for a hearing test
3. Medical Clearance form from the Physician (if necessary)
4. Medical Insurance Cards
5. Completed Privacy Form

Please contact our office within 24 hours (if possible) if you are unable to make your appointment.

Your appointment is scheduled for: ____

Thank you and we look forward to working with you.

Freedom Hearing Center LLC
P.O. Box 3947
Prince Frederick, MD 20678
(P) 410-610-2246/ (Fax) 443-432-3943
info@freedomhearing.com

Comprehensive Case History Form

Today's Date: ____ **( ) Male** **( ) Female**

Patient's Name: ______________________________________ **Date of Birth:** ________________________________

Social Security Number: ________________________________

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Domestic Partner

Home Address: ____

Street or P.O. Box City State Zip Code

Mailing Address (if different): ____

Street or P.O. Box City State Zip Code

Home Phone: ____________________ **Work Phone:** ___________________ **Cell Phone:** _______________________

Emergency Contact: ________________________ **Phone Number:** ____________________ **Relation:** ______________

Current Employment: Full Time Part Time Retired Unemployed Stay at Home Parent Student

Current Employer: ___________________________________ **Position:** _____________________________________

Insurance Information

Primary Insurance: __________________________ **Policy Holder's Name and DOB:** __________________________

Primary Insurance Policy Number: ______________________ **Group Number:** ________________________________

Insurance Telephone Number: ______________________ **Address:** ____

Secondary Insurance: __________________________ **Policy Holder's Name and DOB:** __________________________

Secondary Insurance Policy Number: _____________________ **Group Number:** _______________________________

Policy Holder's Name: __________________________________ **Relation to Patient:** ____________________________

Home Address: ____

Street or P.O. Box City State Zip Code

Referral Source

How did you hear about us? **( ) Doctor** **( ) Family/Friend** **( ) Newspaper Ad/Yellow Pages**

( ) Website **( ) Mailing Piece**

Freedom Hearing Center LLC

Audiologic History

Do you experience hearing loss? Yes No **If Yes, which ear?** Right Left Both

If you experience hearing loss, which best describes it: Gradual Fluctuating Sudden

When did you first notice your hearing loss? ____

What do you think is the cause of your hearing loss? ____

Have you ever had a hearing test: Yes No **If so, when?** ____

Which ear do you use to talk on the phone? Right Left

Have you ever worn or tried a hearing aid: Right ear Left ear Both ears

What type and/or style of hearing aid? ____

Please describe your experience: ____

Please Check All That Apply:

_____ **Dizziness or Vertigo** If Checked, is it accompanied by: Vomiting Nausea Ear Noises

_____ **Ear Drainage** If Checked, Right Ear Left Ear Both Ears

_____ **Ear Pain** If Checked, Right Ear Left Ear Both Ears

_____ **Family History of Hearing Loss** If Checked, who? ____

_____ **History of Ear Infections** If Checked, Right Ear Left Ear Both Ears

_____ **History of Wax Buildup**

_____ **History of Noise Exposure** If Checked, please describe ____

_____ **Ear Surgery** If Checked, please describe ____

_____ **Tinnitus/Ringing/Noises in Ear** If checked, Right Ear Left Ear Both Ears

_____ **Allergies** If Checked, please describe ____

_____ **Tobacco Use** If checked, how much and for how often ____

_____ **Alcoholic Beverages** If Checked, how often ____

8 Diabetes _____ Cancer ______Head Injury _____ AIDS/HIV _____ High Blood Pressure

_____ **Measles _____ Meningitis _____Stroke _____ Mumps _____ Scarlet Fever**

Current Medications (Over the Counter and Prescriptions) ____

____

____

____

P. O. Box 3927
Prince Frederick, MD 20678
410-610-2246

Rebecca L Jahed, AuD, FAAA
Clinical Audiologist
info@freedomhearing.com

Privacy Practices Acknowledgement

I acknowledge that I have received the Notice of Privacy Practices for Freedom Hearing Center LLC and have had an opportunity to review it.   A current copy of this notice will be available on the website and in each office. This notice informs me how Freedom Hearing Center LLC may use and disclose my protected health information for treatment, payment, or as required by law.

Printed Name of Patient __________________________________ Date of Birth ______________________________

Signature of Patient/Guardian ____________________________ Date _____________________________________

Permission to Use and Disclose Protected Health Information

I hereby give permission for Freedom Hearing Center LLC to disclose my protected health information as indicated:

( ) I consent for Freedom Hearing Center LLC to release my Protected Health Information to my family, caregivers, beneficiaries, insurance company, healthcare provider, attorney, school, and employer.

I authorize the above entities except the listed person(s): ____

____

( ) I prohibit Freedom Hearing Center LLC from disclosing my protected health information to any entity other than required by HIPAA regulations.

Signature of Patient/Guardian ____________________________________ Date ___________________________

Payment Responsibility

I understand that I am responsible for all audiological services rendered. Freedom Hearing Center LLC may submit a bill to my insurance company when appropriate, however, that does not relieve my personal obligation should the payment not be covered in full. I agree to pay any outstanding balance and understand that there will be a $25 fee for any returned checks. I give permission for Freedom Hearing Center LLC to submit a claim to my insurance company and authorize the direct payment for any benefits to be sent to Freedom Hearing Center LLC. NOTE: Medicare does not cover hearing aids and will only cover hearing testing with a physician referral and only when they believe it is medically necessary.

Signature of Patient/Guardian ____________________________ Date _____________________________________

Rebecca L Jahed, AuD, FAAA

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Medical Clearance for Hearing Aid Candidacy

PATIENT NAME: ____

The above patient has been medically evaluated and is considered a candidate for a hearing aid. The hearing loss is not due to a temporary, correctable physical condition. There are no contraindications to hearing aid candidacy.

Signed,

____ _______________________________________

Physician Signature Date

____

Physician Name (Please Print)

Rebecca L Jahed, AuD, FAAA
P.O. Box 3927 Prince Frederick, MD 20678
410-610-2246/ info@freedomhearing.com

Release of Information and Assignment

Patient Name ______________________________ Date of Birth ________________________

I request and authorize those listed below to release healthcare information including audiological examinations and treatments to Freedom Hearing Center LLC:

Name of Physician/ Practice or Individual ____

Address ____

Telephone Number ____

Name of Physician/ Practice or Individual ____

Address ____

Telephone Number ____

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I may receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. This authorization will automatically expire: (1) upon satisfaction of the need for disclosure or (2) 90 days from the date requested.

____ ____________________________________

Print Patient Name Date

____

Signature of Patient or Guardian