

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_

City, State and Zip: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Emergency Contact/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Sex: Male [ ] Female [ ]

Employment status: Full Time [ ] Part Time [ ] Unemployed [ ] Student [ ] Retired [ ]

Marital Status: Single [ ] Married [ ] Widowed [ ] Divorced [ ] Domestic Partner [ ]

Other than yourself, with who else can we share/discuss results? \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

I would like my written report to be sent to the following physicians: \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance:**

Plan Name: \_\_\_\_\_ Policy/ID# \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Patient Relationship to Subscriber: \_\_\_\_\_

Subscriber's DOB: \_\_\_\_\_ Subscriber's Employer: \_\_\_\_\_

**Secondary Insurance:**

Plan Name: \_\_\_\_\_ Policy/ID# \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Patient Relationship to Subscriber: \_\_\_\_\_

Subscriber's DOB: \_\_\_\_\_ Subscriber's Employer: \_\_\_\_\_

***\*If you have a third insurance carrier, please let us know***

Many insurance carriers require referral from your Primary Care Physician before you receive care from a specialist; **IT IS YOUR RESPONSIBILITY TO OBTAIN A REFERRAL OR PRIOR AUTHORIZATION IF YOUR MEDICAL COVERAGE REQUIRES IT.**

**Person responsible for payment for services rendered by Freedom Hearing Center**

Guarantor Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City, State, and Zip: \_\_\_\_\_

If the patient is a minor, who is/are the legal guardian(s)? \_\_\_\_\_

I certify that the information I have reported on this form is correct to the best of my knowledge. I understand that if any changes are made to the information above that I notify Freedom Hearing Center. I authorize Freedom Hearing Center to disclose any necessary health information needed for treatment and or payment of services received. I also authorize release of health care information to other health care providers for continuing care and treatment. Lastly, I authorize Freedom Hearing Center to collect any payment made by insurance carrier for services rendered and billed by Freedom Hearing Center. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing. **I understand that nothing herein relieves me of the responsibility and obligation to pay for medical services provided and items purchased when a statement is rendered. Delinquent accounts incur collection, court, and attorney expenses.**

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date



Prince Frederick – Solomons – Leonardtown – Greenbelt  
Diagnostic Hearing Centers  
(P) (443) 295-7100 (F) (443) 295-7555  
Waldorf Diagnostic Hearing & Balance Center  
(P) (301) 374-8477 (F) (301) 374-8432  
www.freedomhearing.com

**Patient's Name:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_  
**Family Doctor:** \_\_\_\_\_ **Referring Doctor:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Address:** \_\_\_\_\_  
\_\_\_\_\_  
**Phone Number:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

1. What is the reason for today's visit? \_\_\_\_\_
2. Will this be your first hearing test?  Yes  No
  - a. If no, when did you have your hearing tested? \_\_\_\_\_
3. Have you ever had ear surgery?  Yes  No
  - a. If yes, explain: \_\_\_\_\_
4. Do you have any of the following:
  - a.  Deformity of the ear  Recent ear drainage  Ear infection
5. Do you feel that your hearing is worse in one ear?  Yes  No
  - a. If so, which ear is worse?  Left  Right
6. Do you experience noises or sounds in your ears?  Yes  No
  - a. If yes, do you experience it in:  Left  Right  Both
7. Have you had sudden or rapid hearing loss in the past 90 days?  Yes  No
8. Have you experienced acute or recurring dizziness?  Yes  No
9. Is there a family history of hearing loss?  Yes  No
  - a. If yes, who? \_\_\_\_\_
10. Do you ever have ear pain?  Yes  No
11. Have you been exposed to loud sounds at work or in hobbies?  Yes  No
12. Do you experience sensations of fullness in the ears?  Yes  No
13. Do you have any of the following:  
 High Blood Pressure  Head Trauma  Hypothyroidism  Cancer  Stroke  
 Heart/Vascular Disease  Mumps/Measles  Meningitis  Diabetes
14. Are you on any medications?  Yes (Please list on the back of this sheet)  No
15. Have you ever worn a hearing aid? \_\_\_\_\_
16. If you are fortunate enough to be helped, are you prepared today to continue on a program for better hearing, which may include the use of hearing aids?  Yes  No
17. Would anything prevent you from wearing hearing aids? \_\_\_\_\_
18. In what situations would you like to hear better? \_\_\_\_\_
19. How did you hear about Freedom Hearing? \_\_\_\_\_

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Date: \_\_\_\_\_

## **Late Arrival, No Show, and Cancellation Policy**

At Freedom Hearing Center, our goal is to provide quality audiological care in a timely manner. We have implemented a no show/cancellation policy for all appointments, which enables us to better utilize the time reserved for each individual patient.

### **Cancellation of Appointments**

Please be courteous and call our office promptly if you are unable to make your appointment. This time will be reallocated to someone who needs treatment.

If it is necessary to cancel your scheduled office appointment, **we require a 24-hour notice**. Early cancellation will give us the opportunity to provide services to another patient in need.

### **No Show**

A “no-show” is someone who misses an appointment without canceling 24 hours in advance. No-shows not only inconvenience our staff, but they also inconvenience other patients in need of audiological care. Failure to arrive at the time of a scheduled appointment will be considered “no-show”. More than 2 no shows will result in being discharged from our practice.

**No shows and cancellations with less than a 24 hour notice will receive an invoice for \$50 to cover office time. This fee is the patient’s responsibility, NO insurance will be filed.**

**Vestibular and Cochlear Implant appointments are lengthy appointments and should be cancelled 48 hours in advance. Otherwise, there will be a \$150 no show/cancellation fee applied to your bill.**

By signing this document, you agree to and understand our Late Arrival, No Show, and Cancellation Policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

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## Notice of Privacy Practices

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.**

### UNDERSTANDING YOUR HEALTH RECORD/INFORMATION:

Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment and personal demographics (i.e. address, date of birth, health insurance etc.) This information, often referred to as your health or medical record, serves as basis for planning your care and treatment, and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understanding who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

### YOUR HEALTH INFORMATION RIGHTS:

Your health record belongs to you, unless otherwise required by law that it is the physical property of the healthcare practitioner or facility that compiled it. You have the right to request a restriction on certain uses and disclosures of your information, and request amendments to your health record. This includes the right to obtain a paper copy of the notice of information practices upon request, inspect and obtain a copy of your health record, obtain an accounting of the disclosures of your health information, request communications of your health information by alternatives means or alternative locations, revoke your authorization to use or disclose health information except to the extent that action has already been taken.

### OUR RESPONSIBILITIES:

This organization is required to maintain the privacy of your health information. In addition, provide you with notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. This organization must abide by the terms of this notice; notify you if we are unable to agree to a requested restriction; accommodate reasonable requests you may have to communicate health information by alternative means or alternative locations. We reserve the right to change our practices and to make the provisions effective for all protected health information we maintain. Should our information practices change, we will be happy to provide an updated copy upon request as well as provide an updated copy on our website. We will not use or disclose your health information without your authorization, except as described in this notice.

### Your health information will be used in the following ways:

- 1) We will use your health information for treatment. Information obtained by a healthcare practitioner will be recorded in your record and used to determine the course of treatment that should work best for you. We will also provide your other practitioners with copies of various reports that should assist them in treating you.
- 2) We will use your health information for payment. A bill may be sent to you, or a third-party payer. The information on/or accompanying the bill may include information that identifies you, your diagnosis, procedures, and supplies used.
- 3) We will use your health information for regular health operations. Staff members may use information in your health record to access the care and outcomes in your case and others like it. This information will then be used in effort to continually improve the quality and effectiveness of the healthcare and service we provide.
- 4) We may disclose some of your health information to our Business Associates (i.e. hearing aid manufacturers or earmold labs) so that they can perform the work required. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.
- 5) We may use or disclose information to notify or assist in notifying a family member, personal representative, or other person for your care, your location and/or general condition.

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- 6) We may disclose to a family member, other relatives, or close personal friends, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.
- 7) As required by law, we may disclose to the FDA health information relative to adverse events with respect to product defects, or post marketing surveillance information to enable product recalls, repairs, or replacements.
- 8) We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, such as the Division of Rehabilitative Services.
- 9) As required by law, we may disclose your health information to public health or legal authorities charged with tracking birth and deaths, as well as with preventing or controlling disease, injury or disability.
- 10) Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of the other individuals. An inmate does not have the right to the Notice of Privacy Practices.
- 11) We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provide that a work force member or business associate believe in good faith that we engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.
- 12) We may contact you by telephone, mail, or email to provide appointment reminders, warranty expiration reminders, information about treatment alternatives, other related health information, or services/products that may be of interest to you.

### IDENTITY THEFT PREVENTION AND DETECTION

It is the policy of this practice to follow all federal and state laws in protecting your private information and reporting requirements regarding identity theft as per the Red Flag Rules compliance program. To protect your identity Freedom Hearing will ask for the following to protect you:

- Driver's license or other type photo ID
- Current health insurance card
- Utility bill or other correspondence showing current residence if your photo ID does not show a current address

Should Freedom Hearing suspect fraudulent activity (a red flag), Freedom Hearing reserves the right to:

- Cancel the transaction
- Contact the appropriate enforcement
- Notify the affected person
- Notify affected physician(s)

This notice will be maintained on our website and patients will be provided a hard copy upon request.

### FOR MORE INFORMATION, OR TO REPORT A PROBLEM:

If you have questions, and would like additional information, you may contact Freedom Hearing directly at 443-295-7100. If you believe your privacy rights have been violated, you can file a complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

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I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used as outlined in Freedom Hearing Center’s **Notice of Privacy Practices**. Specifically, I understand that my PHI will be used to:

- ✓ Conduct, plan and direct my treatment and follow-up among multiple Healthcare providers who may be involved in that treatment directly and indirectly.
- ✓ Obtain payment from third-party payers (i.e. my insurance company).
- ✓ Conduct normal healthcare operations such as quality assessments and physician certifications.
- ✓ Provide appointment reminders, warranty expiration reminders, information about treatment alternatives, other related health information, or products/services that may be of interest to me.

I have been informed of your **Notice of Privacy Practices** policy containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such **Notice of Privacy Practices** prior to signing this consent. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time, and that I may contact this organization at any time by telephone or at the address below to obtain a correct copy of the **Notice of Privacy Practices**. I may also find the most recent **Notice of Privacy Practices** online at [www.freedomhearing.com](http://www.freedomhearing.com).

I understand that I may request verbally or in writing that you restrict how my private information is used and disclosed to carry out treatment, payment, or healthcare operations, but you are not required to agree to these requested restrictions. However, if you do agree, then you are bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Other than yourself, with whom else may we share/discuss results? \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

\*If you have questions, and would like additional information, you may contact Freedom Hearing Center and ask to speak with our HIPAA Privacy Officer, Pamela McIntyre at 443-295-7100.

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