Patient Intake Form

Patient Name :
DOB :
Phone:

Integrity Hearing Services
7525 Custer Rd W
Lakewood, WA 98499
253-476-4327 Phone
253-476-0585 Fax

Welcome to Integrity Hearing Services

Welcome to our office!

We are happy you have decided to let us participate in your hearing health care and we look forward to meeting you at your first appointment.

A little bit about us….
Integrity Hearing Services was started by our founding Audiologist, Dr, Danette Jackson in 2005. She has been an Audiologist for over 34 years. Our mission statement is:

"We are here to help people hear so that they can fully participate in their lives and the lives of the people they love."

Please note the following:

1. If you have had any loud noise exposure 14 hours prior to your appointment, it will affect your test results.
2. If you have any medical conditions, please let us know by noting details on the enclosed History Form, as this may be a factor in your recent hearing loss.
3. Please bring a valid photo ID and ALL insurance cards to your appointment. If you forget your insurance cards, your visit will be treated as a private pay. We are required to verify insurance prior to your visit. If we have not been given the information, your appointment may be canceled or treated as private pay.
4. If the patient is a minor, a parent or legal guardian must be present at the time of service. We do not specialize in pediatrics. Therefore, prior exception must be granted.
5. If anyone other than the patient is the responsible party, e.g. power of attorney, that person will need to be present at the time of service and a copy of the documentation must be scanned into the patient's chart.

Enclosed are your New Patient information forms. Please return the forms at least one week prior to your appointment. New pre-authorization standards are required. Co-Pay is required the day of your appointment. Please call to verify with your insurance company if you have any questions. It is a courtesy for us to bill your insurance. The balance is the patient's responsibility if your insurance company denies the charges. We thank you in advance for timely payment of any balance that may need your assistance.

Check in is 10 minutes before your appointment.
If you have any questions, you can reach our staff at (253) 476-4327 or at scheduling@integrityhearingservices.com

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Patient Registration

Please complete this registration packet and email prior to your appointment along with insurance cards and photo ID. Referrals and co-payments are due at the time of your visit.

First Name: ________________________________ MI: ___________ Last Name: _____________________________
Date of Birth: ____________________ Nickname/Preferred Name: ____
Social Security #: _______________________ Sex: M F

Address: ____ City:
____ State: ______________________ Zip Code: _______________ Home
Phone: ________________________ Cell Phone: ______________________ Is Text Okay?:_________________ Email
Address: ____

Whom may we thank for referring you? ____

Patient's Profession: ______________________ Patient's Employer: ____
Employer Address: ____ Phone: ______________________

Emergency Contact: ________________________Relationship: __________________ Phone: ____________________

Person Responsible for Payment: _____________________________________Claim# ___________________________
Driver's License #: ____ SS#: __________________________

Is there anything we should know about your culture, beliefs, or religious practices that would help us take better care of you? NO ☐YES ☐ If YES, please note briefly. Your audiologist will discuss further during your appointment.

____

ALL INFO REQUIRED IN ADDITION TO COPY OF CARD(S)

Primary Insurance: ________________________ ID #: ___________________________ Group #: ________________
Secondary Insurance: ______________________ ID #: ___________________________ Group #: ________________
Is the patient the insurance subscriber?
☐YES – Skip to physician info ☐NO – Please complete info below:
Subscriber's Name:____________________________________ Relationship: __________________________________
Subscriber's DOB:_____________________________________ SS#: ____
Address if different from patient: ____
Subscriber's Employer: ____
Employer Address: ____
City: ____ State: ____________________ Zip Code: _______________

Primary Care Physician: _____________________________________ NPI #: ___________________________________
Phone: ____ FAX: ____________________________________
Other relevant physicians (i.e. ENT, Neurologist): ____
Do we have your permission to send a report to the physician(s) listed above (recommended): Yes No

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PLEASE READ, COMPLETE, AND SIGN THE PRIVACY AND FINANCIAL POLICY FORMS INCLUDED IN THIS PACKET

Integrity Hearing Services Financial and Treatment Policy

Thank you for choosing us as your hearing healthcare provider. We are committed to your treatment being successful. The following is a statement of our financial and treatment policy, which we require you to read and sign prior to any evaluation or treatment. Please let us know if you have any questions regarding this policy.

COPAYMENTS are due at the time of visit. MEDICARE requires a physician's order and a signed Advanced Beneficiary Notice acknowledging patient responsibility for all audiology services. REFERRALS and PHYSICIAN ORDERS are due one week before date of service. We accept CASH, CHECKS, VISA, MASTERCARD.

Refund Policy

All accessories and refund items will be returned at full price before they are opened. Earmolds and earplugs are non-refundable. All hearing aid refunds will be returned within the trial period with the exception of a $150 fitting fee per ear which covers costs we cannot recover (i.e. shipping and handling, restocking and credit card fees). All payments made by Visa or MasterCard will be refunded back to the original card that the payment was made with. All other payments will be refunded by check. All REFUNDS are issued back onto the card you used.

Regarding Treatment

The undersigned consents to the provision of medical care, diagnosis and/or treatment rendered by Integrity Hearing Services, PC.

Regarding Cancellation or Missed Appointments

For all patients, if you are unable to make a scheduled appointment for any reason, we require at least 24 hours' notice to cancel your appointment. You may cancel by phone, text message, or email. If you fail to cancel your appointment with at least 24 hours' notice, or if you fail to show up to your scheduled appointment without canceling, you will be subject to a $50 cancellation fee. Three late cancellations and/or no shows will result in your preclusion from future services with IHS. Patients will be informed upon being precluded from future services.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. **Please make sure that you understand your insurance policy. Please be aware that some and perhaps all of the services rendered may be a non-covered benefit under your plan's policy and therefore will be your responsibility. All co-pays, deductibles, and co-insurances that you have will be billed to you as indicated by your insurance company.** A quote of benefits and/or Pre-authorizations does not guarantee payments or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the members' contract with their insurance at the time of service. We are participating providers with most insurance carriers. If your insurance company denies your claim, we will make reasonable effort to resolve their denial. If your insurance has not paid your claim within 60 days, you may be responsible for payment in full. If you belong to an HMO, MCO, or POS, it is your responsibility to obtain a referral from your primary care physician's office. If you are seen without a referral, payment will be due at the time of service. If your referral is sent and your provider does not have Medicare referring rights, you may be responsible for the full balance.

Usual and Customary

Our practice is committed to providing the best hearing healthcare for our patients, and we charge what is usual and customary for our area. **For insurance carriers not contracted with us**, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Your EOB is the explanation of your benefits. You are still responsible for the **FULL REMAINDER OF THE BALANCE** *unless your benefit states we are unable to balance bill.*

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Past Due Accounts

Integrity Hearing Services will file your claim with your insurance, **if we participate with your insurance**; otherwise, payment is required in full for all services at the time they are rendered. You are responsible for all charges not covered by your insurance company. All co-payments and deductibles are to be paid in full within 90 days of your first statement being generated. Unpaid balances after 90 days will incur a $5.00 statement fee. Unpaid balances that are turned over to an external collection agency will incur a fee of 25% of the amount due on the account. You are responsible for all legal fees if your account is turned over to a lawyer for collection. Your signature below signifies your understanding and willingness to comply with this policy.

Check Return Policy

Returned check may be assessed up to a $75.00 service charge (per resubmit to bank).

L&I Claims:

If you have an L&I claim you will need to notify the front desk on your appointment date. We will need your L&I claim Information, including; claim number, date of injury and your claim managers contact information, for us to bill for you. If you do not give us this information, you will be responsible for the bill. Pre-authorizations are required for most insurance companies starting in 2024. Without the pre-authorization the bill is the responsibility of the patient. Please ensure you have given plenty of time prior to your appointment for the authorization to be obtained.

Referral Request

Medicare and several other insurances require referrals for our office to bill. Please fill out this section for us to be able to send a referral request on your behalf. If this section is not filled in, we will not be able to complete the appointment due to the inability to bill your insurance.

Your Primary Care Provider's Name: ____
Address: ____
Phone Number: _________________ Fax Number: ________________NPI Number: ________________

Pre-Authorization for Service

If a Pre Auth is required for your appointment you will need to supply the following information:

Subscriber Name: ______________________________ Subscriber DOB: ________________________
Payer ID for your Insurance: __________________ Customer Service# for Authorization: ________________

Authorization

☐ I authorize the release of information to primary/secondary insurance companies. I understand that I am responsible for my bill (Both parent(s) and legal guardian(s) are responsible for the minor's bill).

☐ I authorize payment directly to Integrity Hearing Services, PS. I permit a copy of this authorization to be used in place of an original. I have read pages 1 and 2 of the policy above and understand and agree to terms as list.

ALL PAPERWORK MUST BETURNED IN ONE WEEK PRIOR TO YOUR APPOINTMENT WITH A COPY OF ALL INSURANCE CARDS AND YOUR ID. PLEASE RRIVE 10 MINUTES BEFORE YOUR APPOINTMENT FOR CHECK IN.

_______________________________________ ________________________
Signature of Responsible Party Date

_______________________________________ ________________________
Signature of Co-Responsible Party Date

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Integrity Hearing Services, PS
Health Information Privacy and Affordability Act (HIPAA) Packet

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

- This Notice informs me how Integrity Hearing Services, PS will use my health information for the purposes of my treatment and/or payment for my treatment and to contact me for reminders for upcoming appointments.
- This Notice explains in more detail how Integrity Hearing Services, PS. may use and share my health information for other than treatment, payment, and health care operations.
- Integrity Hearing Services, PS will also use and share my health information as required/permitted by law.
- I acknowledge that I received a copy of Integrity Hearing Services, PS Notice of Privacy Practices.
- I further acknowledge that a copy of the current notice is posted in the reception area and on our website and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment if amended.

I consent to Integrity Hearing Services, PS. releasing protected health information as detailed above. Please list names of FAMILY or PERSONAL REPRESENTATIVES we may disclose information to in the event that you are unable to contact us directly for any related Audiological questions or needs pertaining to your care and/or financial issues.

Name ____________________________Relationship______________________ # _____________________________
Name ____________________________Relationship______________________ # _____________________________
Name ____________________________Relationship______________________ # _____________________________
Name ____________________________Relationship______________________ # _____________________________

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to Integrity Hearing Services, PS to the address listed at the bottom of this form. I understand that revocation of this authorization will not affect any action the above-named entity took in reliance on those authorization before the above-named entity received my written notice of revocation.

I authorize Integrity Hearing Services, PS. to use and disclose my protected health information as set forth above. I understand that this authorization is voluntary and that Integrity Hearing Services cannot condition my treatment, service, etc., on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship. This authorization will expire (1) one year from the date it is signed.

____ ___________________________________
Printed name of patient or personal representative Date of Birth

____ ___________________________________
Signature of patient or personal representative Date Signed

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Adult History Form

Patient Name: ________________________DOB: __________________ Today's Date: _____________

What brings you in to see us today? ____
When was your last hearing test? ____
Please check if you have any of these health issues:

- Ear pain? ____
- Ear fullness or blocked feeling? ____
- Ringing or noises in ears? ____
- Dizziness? ____
- Facial numbness? ____
- Have you had a recent cold or influenza? ____
- Sinus problems? ____
- Allergy problems? ____
- History of depression? ____
  - Head or neck surgery
  - Diabetes
  - Heart
  - Radiation/Chemotherapy
  - Circulatory
  - Memory Loss or Cognitive Issues
  - Kidney Disease
  - Pacemaker
  - Other allergies?

  Please list: ____
- Use of tobacco one or more times in the last 24 months (cigarettes, cigars, smokeless tobacco)? • Yes • No
- Have you ever been diagnosed with COVID-19? • Yes When? ________________• No
- Additional comments to discuss with the audiologist: ___________________________________

____

Please CHECK MARK frequency of difficulty of hearing in each situation:

One on one conversation:	☐Never	☐ Sometimes	☐ Frequently	☐Always
Television:	☐Never	☐ Sometimes	☐ Frequently	☐Always
Small Groups/Family Gatherings:	☐Never	☐ Sometimes	☐ Frequently	☐Always
Quiet Restaurants:	☐Never	☐ Sometimes	☐ Frequently	☐Always
Noisy Restaurants/Parties	☐Never	☐ Sometimes	☐ Frequently	☐Always
Telephone:	☐Never	☐ Sometimes	☐ Frequently	☐Always
Car Rides:	☐Never	☐ Sometimes	☐ Frequently	☐Always
Church:	☐Never	☐ Sometimes	☐ Frequently	☐Always

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Medications

Medication Name	Dosage	Frequency	Route (i.e. oral)	For what medical condition?

Tinnitus History

Marital Status:

☐Single ☐Married ☐Widowed

Highest level of education completed:

☐ 12th grade or less ☐ High School/GED ☐ Vocational Training ☐ College ☐ Graduate School

Occupation: ______________________________

Referred to clinic by:

Primary Physician: ______________________________

ENT or Otologist: ______________________________

Audiologist: ______________________________

Relative / Friend: ______________________________

Other : ______________________________

1. Grade the severity of each of the following based on a scale of 0 - 10 (a "10" being the worst).

Circe your answer and please circle "O" I fit does not apply.

Hearing Loss:	0	1	2	3	4	5	6	7	8	9	10
Tinnitus:	0	1	2	3	4	5	6	7	8	9	10
Hyperacusis:	0	1	2	3	4	5	6	7	8	9	10
Depression:	0	1	2	3	4	5	6	7	8	9	10

2. Grade the overall loudness of your most troublesome tinnitus.

Softest Loudest

0 1 2 3 4 5 6 7 8 9 10

3. Grade the impact the tinnitus has on your quality of life, using a "0" so "10" scale.

None Completely Ruined

0 1 2 3 4 5 6 7 8 9 10

4. What portion of your waking hours on average are you aware of your Tinnitus if you do not purposefully listen for 5?

Circle One

>10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

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5. If you have hyperacusis (sensitivity to everyday sound), grade the impact hyperacusis has on your quality of life:

None   Completely Ruined
0 1 2 3 4 5 6 7 8 9 10

AUTHORIZATION TO USE OR DISCLOSE HEALTH CARE INFORMATION

Patient Last Name: ______________________ First Name: ________________Previous Name(s): ____________
IHS Acct #: _____________________________ SSN: _______________________ Date of Birth: ________________
Contact Phone Number: _________________________________ Cell Number: ____________________________

Information to be released:

- All records in the last three years and pertinent chart information (i.e. audios, testing, reports, notes)
- Recent Audio/Hearing Testing
- Other: ____

Purpose of release:

- Coordination of care/transfer of care
- Patient request
- Employment
- Academics
- Payment/insurance claims
- Life insurance/disability claims
- Attorney/legal request
- Other

Information to be released FROM:
Name/Title/Organization: ____
Address: ____ State: _____________Zip: _____________
Phone: _____________________________Fax: ____________________Attn to: ____________________________

Information to be released TO:
Name/Title/Organization: ____
Address: ____ State: ___________ Zip: ______________

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Phone: ____________________________Fax: ____________________Attn to: ____________________________

My Rights:

This release shall expire on (date) ________________________________

____ ______________________________

Patient or legally authorized individual signature Date Time

____ ______________________________

Printed Name Relationship to patient

Updated Adult History Form

Patient Name: ________________________ DOB: ___________ Today's Date: _____________

What brings you in to see us today? ____
What changes have you had since your last visit? _________________________________
Are there improvements?
Explain please: ____

- Ear pain? ____
- Any blocked feeling? ____
- Ringing or noises in ears? ____
- Do you have any dizziness? ____
- Have you fallen since your last visit? ____
- Do you feel any Facial numbness? ____
- Have you had a recent cold or influenza? ____________________________________
- Do you have sinus problems? ____
- Do you have allergy problems? ____
- History of depression? ____

Please check if you have any of these health issues:

- Head or neck surgery • Diabetes
- Heart
- Radiation/Chemotherapy
- Circulatory • Memory Loss or Cognitive Issues
- Kidney disease • Pacemaker • Other allergies?

Please list: ____

15. Use of tobacco one or more times in the last 24 months (cigarettes, cigars, smokeless tobacco)? • Yes • No
16. Have you ever been diagnosed with COVID-19? • Yes When? _____________ • No
17. Additional comments to discuss with the audiologist: ___________________________

<u>Any changes in your medications or vitamins since your last appointment?</u>

• Yes – List below; Continue on back if needed • No

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Medication Name	Dosage	Frequency	Route (i.e. oral)
______________	______	______	________
______________	______	______	________
______________	______	______	________

What Medical condition are you taking these meds?

____

______________________ ______________________

Patient Signature Date of Service

FAX/EMAIL

Thursday, March 7, 2024

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

From: Integrity Hearing Services

Phone: 253-476-4327

Fax: 253-476-0585

Company Name: Integrity Hearing Services

To: Dr.

Phone: [Type the recipient phone number]

Fax: [Type the recipient fax number]

Company Name: [Type the recipient company name]

RE: Type Patient Name

Date of Birth: Type Date of Birth

☐Medical Clearance

☐Referral

Pt is requesting a referral
For a hearing test. Please
Fax a referral ASAP. We will
Send report when the appointment
is complete.

DOS: ____________________

☐Records Requests ☐See Enclosed

Your patient is requesting records
For the indicated dates and information:

Medical Clearance Request

I am signing and dating this document for my patient, giving consent for medical clearance. I have received Audiogram and Report of Diagnosis and am fully aware of his/her intension to proceed.

Providers Medical Clearance: __________________

- **H90.3** - Sensorineural hearing loss, bilateral, both ears
- **H90.41** - Sensorineural hearing loss, unilateral
- **H90.42** - Sensorineural hearing loss, unilateral left ear

Signature: ______________________________

Address: ______________________________

NPI: ______________________

Date: _____________

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Date: ___________________________

Requested Information: _______________________

____

☐Sending Reports

We are sending you records/Reports in regards to
Your patient. If you have any questions please call
And let us know.

Thank you. Integrity Hearing Services

NOTES: