Welcome to PAC Audiology

1370 116th Ave. NE Suite 201
Bellevue, WA 98004
www.pacaudiology.com
425-455-0526

What to Expect at your Appointment?

Your visit will include a variety of tests. Your appointment will be 2 hours. We make every attempt to make your visit comfortable as well as educational. We will discuss the results and send all results to your referring physician.

DOs and DON'Ts

So we can obtain accurate results, we ask that you please review the following instructions:

1. Bring photo ID, insurance card(s), and a list of medications.
2. Get a good night's rest before your appointment.
3. Reduce your intake of alcohol and nicotine 24 hours before your appointment.
4. Avoid exposure to overly loud noises before a hearing evaluation.
5. Bring your past test results including MRI/CT scan results.
6. Prepare to tell your doctor about any other health conditions you have, such as hearing loss, high blood pressure, or clogged arteries. You should also list all medications you take, including herbal remedies.

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Intake form for Sound Sensitivity

Mr. Mrs. Ms. Dr. They

OK to leave a voicemail? Yes No
OK to send a text message? Yes No

Patient Name _____ Male Female Unisex
First Last MI

Address _____City_____State____Zip_____

Birth Date _____ Age _____ Email Address_____

Home/Cell Phone_____ Work Phone_____

Employer _____ Occupation_____

Primary Care Physician _____ Phone #_____

Referring Doctor _____ Phone #_____

How did you hear about us? _____

Emergency Contact Name_____ Relationship to Patient_____
Emergency Phone Number/Email Address_____

I authorize PAC Audiology to call and/or leave messages regarding appointments, patient care and billing at the following individual(s): NAME _____ RELATIONSHIP _____ PHONE _____

Please complete Insurance Primary Subscriber's Information, if different from patient

Primary subscriber_____ Birth Date_____
Address (if different) _____
Home/Cell Phone _____Work Phone _____

Insurance Release Agreement

We will place a copy of your insurance card and photo ID in chart and bill your insurance for this visit. If correct information is not provided at time of service, you will be responsible for all charges as billed and an **additional $25 Rebilling Fee.** I hereby authorize PAC Audiology to release any information necessary to process insurance claim forms. I also authorize my insurance claim to be paid directly to the clinic.

SIGNATURE _____ **Date** _____

_____ _____
Please PRINT name if signing as parent or guardian **Relationship to patient**

I hereby designate the following individual(s) to receive communications from PAC Audiology that may include health information about me.

Referral MD/PCP: _____
School/Name of Teacher/Counselor: _____

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Confidentiality and Privacy Policy

The purpose of this policy is to protect a patient's right to confidentiality and privacy. Patient information will be regarded as confidential and will be available only to authorized users for approved purposes. Every Provider, Staff, Contractor or Student will use only the minimum amount of confidential patient information to accomplish their assigned duties. Access to confidential information is only permitted for direct patient care, billing, or administrative operations.

Discussion or consultation involving a patient's care should be conducted in private. Individuals not directly involved in the patient's care should not be present without the patient's permission.

1. Discuss patient information with authorized personnel only and only in a private location where unauthorized persons cannot overhear.
2. Minimize how audible we are when discussing patient information on the phone while keeping in mind that sometimes we must speak loudly for our patients who are hard of hearing.
3. Keep medical records secure and unavailable to persons not involved with the patient's care.
4. Follow specified procedures for use of electronic information systems, including use of passwords, logging off when finished, and protection of displayed or printed information from unauthorized users.
5. Omit the patient's name and other unique identification when using case reports for educational purposes.
6. Verify with the patient what information may be given to the patient's family and friends with the patient's knowledge and permission.
7. Release patient medical records to external sources only upon receipt of written authorization from the patient.
8. Obtain permission from the patient before we use either their email or home address to send them marketing material, patient newsletters, or any other general information regarding PAC Audiology.

PATIENT AGREEMENT

Please initial the following:

_____ By my signature below, I acknowledge that a copy of the PAC Audiology's Confidentiality and Privacy Policy has been made available to me.

_____ I have provided PAC Audiology with my current insurance information. I understand that ultimately the charges for their services will be my responsibility. I authorize any holder of medical or other information about me to release and information needed to process this or other claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

_____ I authorize PAC Audiology to contact me regarding evaluations; recall notices or any general information about PAC Audiology such as any changes in our address, phone number, hours of operation etc…

Signature: _____ Date:_____

_____ _____

Please PRINT name if signing as parent or guardian Relations to patient

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Intake form for Sound Sensitivity

What are your main concerns? (please complete appropriate sections below)

☐ **Hearing Difficulty** ☐ **Tinnitus/Ringing** ☐ **Feeling of ear pressure**

☐ **Dizziness** ☐ **Sound sensitivity** ☐ **Hearing check**

Hearing Difficulty:

Describe your hearing issues: _____

When did your problem begin? _____

Has your hearing changed? **Sudden Gradual Stable**

Which ear do you hear well? **Right Left Don't know**

When was your last hearing exam? _____

	YES	**NO**
Do you avoid social events because it is hard to hear?	☐	☐
Do you need to ask people to repeat themselves?	☐	☐
Is it hard to understand people in loud places?	☐	☐
Do others say the TV is too loud?	☐	☐
Have you noticed that people seem to mumble?	☐	☐
Have you been told that you speak loudly?	☐	☐

Tinnitus/Ringing (Noise in the ear):

Describe the sound:_____

_____

Right ear_____ Left ear_____ When did it first start?_____

Is it constant or periodic?_Is it in time with your heart beat? ___ Does it fluctuate in intensity? ___

What makes it worse? _____ What makes it better? _____

Describe previous treatments_____

_____

_____

Feeling of pressure or plugging(fullness):

When did the sensation begin?_____

Right ear_____ Left ear_____ Both_____

Constant or periodic?____if periodic, how often?_____

Any history of popping sensation? ☐ ☐

Dizziness:

Describe the symptoms?_____

When did it first occur?_____

Constant or periodic? _____if periodic, how long does it last?_____

Sound sensitivity:

Describe your sound sensitivity issues: _____

_____

When did your problem begin?_____

Which ear is affected? **Right Left Both**

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Noise History: **YES** **NO**

Do you have military experience? ☐ ☐
Do you have factory jobs? ☐ ☐
When in loud situations I use ear protection? ☐ ☐
Have you done any of the following? Please circle those that apply.

Chain saw dirt bike firearms concerts/loud music
Lawn equipment wood working other loud noises

Medical History: **YES** **NO**

Do you have a history of ear infections? ☐ ☐
If so, please describe treatments. _____
Do you have a history of punctured/ruptured eardrum? ☐ ☐ If so, when? _____
Do you still have your tonsils? ☐ ☐
In the past 90 days have you had ear pain? ☐ ☐
In the past 90 days have you had ear discharge? ☐ ☐
Do you have a family history of hearing loss? ☐ ☐
If so, who had hearing loss? _____
Have you seen a physician about an ear problem in the last 6 months? ☐ ☐

Please list medication you are taking or provide your medication list:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Please circle any of the following physical conditions you have had….

ear surgery ear malformations allergies
cleft palate kidney trouble diabetes Type I/Type II
fragile bones fainting spells high blood pressure
head injury mumps scarlet fever
measles meningitis cancer
chronic conditions ER Visits overnight Hospitalization
meniere's disease otosclerosis cholesteatoma
sudden hearing loss attention disorders anxiety disorders
depression disorders dexterity disorders Sinus GERD
Loose dentures Jaw pain Mouth guard
Grinding and clicking sensations in the jaw

others_____