PAC Audiology
1370 116th Ave. NE #201 Bellevue, WA 98004 (425) 455-0526 pacaudiology.com

OK to leave a voicemail? Yes No

Patient Name_____Male____Female__
Last First MI
Street Address_____
City_____State_____Zip_____
Home Phone_____ Cell/Work Phone_____
Birth Date _____ Age _____ Email Address_____
Employer _____ Occupation _____
Primary Care Physician _____ Phone #_____
Referring Doctor _____ Phone #_____

In Case of Emergency

Name_____ Relationship to Patient_____
Contact Phone Number(s)_____

Insurance Subscriber's Information
If different from patient

Name_____ Birth Date _____
Mailing Address_____
City_____State_____Zip_____
Home Phone _____Work Phone _____

Insurance

Please provide us with your insurance card and we will make a copy to place in chart. **Co-Pays not received at time of service will incur an additional $25.00 Billing Fee.**

Release

Please Note: We are happy to 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.** If your insurance does not pay within 30 days, you will accept full responsibility of balance.
Release: 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.

PATIENT SIGNATURE _____ Date _____

PARENT, LEGAL GUARDIAN, OR PATIENT REPRESENTATIVE

SIGNATURE _____ Date _____

Please Print Name_____

Relationship_____

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Person completing form:_____Relation to patient:_____

1) Primary Concern:

Do you feel this child has a hearing loss? Yes ☐ No ☐

Explain:_____

Are you concerned about the child's speech or language development? Yes ☐ No ☐

Describe concern:_____

2) Prenatal/ Birth history:

Length of pregnancy?_____Birth weight?_____APGAR Score_____

List medication/drugs used during pregnancy including alcohol:

_____

Is there a family history of hearing loss? Yes ☐ No ☐

If yes, what is the age of onset? _____

Please answer Yes or No:

Unusual Pregnancy:_____ Yes ☐ No ☐

Illness while pregnant (Herpes,Syphilis,Rubella,CMV) Yes ☐ No ☐

Complicated delivery? Yes ☐ No ☐

After birth did this child have:

Newborn hearing screen? Yes ☐ No ☐

Breathing difficulties (ventilation)? Yes ☐ No ☐

Admission to Intensive Care Unit? Yes ☐ No ☐

Head, Neck, or ear abnormalities? Yes ☐ No ☐

Skin tags or pits near the ears? Yes ☐ No ☐

Jaundice (high bilirubin)? Yes ☐ No ☐

Head trauma/defects? Yes ☐ No ☐

Surgery? Yes ☐ No ☐

Diagnosis of neurologic condition? Yes ☐ No ☐

Vision problems? Yes ☐ No ☐

Kidney problems? Yes ☐ No ☐

Overnight hospital stays? Yes ☐ No ☐

Emergency room visits? Yes ☐ No ☐

Other?_____

3) Communication and Development:

Difficulties with pronunciation? Yes ☐ No ☐

Language development concerns? Yes ☐ No ☐

Difficulties listening/understanding? Yes ☐ No ☐

Attention problems at school? Yes ☐ No ☐

Other developmental delays? Yes ☐ No ☐

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Hearing and Middle Ear History:

Pervious hearing test?	Yes ☐ No ☐
Allergies?	Yes ☐ No ☐
Loud noise exposure?	Yes ☐ No ☐
Balance or coordination problems?	Yes ☐ No ☐

Middle ear health:

Number of ear infections?_____ Age resolved? _____

P.E Tubes placed? Yes ☐ No ☐

If yes, who placed tubes, and at what age? _____

History of ear pain? Yes ☐ No ☐

Medications child currently taking? _____

General:

Child responds to sounds and voices?	Yes ☐ No ☐
Child startles at loud noise?	Yes ☐ No ☐
Child looks for the source of sounds?	Yes ☐ No ☐

Please list any medication the child is taking:

_____

_____

_____

_____

Please describe any other physical or health conditions the child:

_____

_____

_____

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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. The copy of the PAC Audiology's Privacy Policy is on the next page.

_____ 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 my self 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…

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

1. NAME _____ RELATIONSHIP _____ PHONE _____
2. NAME _____ RELATIONSHIP _____ PHONE _____

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: _____

Signature: _____ Date:_____

_____ _____

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

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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.

Policy Elements:

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.

All patients will be given a copy of this policy when they check in for their appointment. We will also ask of our patients to sign a form stating that they have received a copy of this policy.