Bright Audiology
1620 South Third Street
Sanford, NC 27330
919-774-3277

Name: First _____ Middle _____ Last _____

Date of Birth _____ SSN # _____

Street Address: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____ E-mail: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell: ( ) _____

Employer: _____

Emergency Contact: _____ Phone: _____

Parent/Guardian Name (if applicable) _____

Primary Insurance: _____ Patient Relation to Insured: Self Spouse Child

Primary Card Holder's Date of Birth _____

Other Insurance: _____ Patient Relation to Insured: Self Spouse Child

Primary Card Holder's Date of Birth _____

Primary Physician _____

How did you hear about us? (Circle all that apply)

Doctor _____ Family _____
Friend _____ Other _____
Yellow pages: Lee County Chatham County Moore County
Newspaper Sanford Herald Chatham Record
Radio _____

- I attest that the above information is true to the best of my knowledge.
- I have been given and read the HIPPA Notice of Patient Information.
- I understand if a confirmed appointment is not kept I will be charged $25 for a broken appointment.
- I understand that if I have earwax, it will be removed at a cost to me so that my appointment can continue. If I choose to go to another provider, I will be charged a $25 fee for a broken appointment.
- I understand that if my insurance is filed, payment will be paid directly to Bright Audiology, unless otherwise agreed to in writing. **I accept full financial responsibility for all charges not covered by insurance.** I acknowledge that payment is due at the time of service, unless other arrangements are made.

_____ _____
Signature Date

BRIGHT AUDIOLOGY
NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL RECORDS MAY BE USED OR DISCLOSED AND HOW YOU CAN ACCESS YOUR MEDICAL RECORDS. PLEASE REVIEW IT CAREFULLY.

Bright Audiology , Inc.'s Legal Duty

Bright Audiology is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Bright Audiology uses your personal health information primarily for treatment, obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example: **Bright Audiology** may use your personal health information to contact you to provide appointment reminders, information about treatment alternatives, or other health related benefits/offers that could be of interest to you.

Bright Audiology may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes and for emergencies. We also provide information when required by law.

In any situation, Bright **Audiology's policy** is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Bright Audiology may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you when required by law or in emergency circumstances. **Bright Audiology** will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Bright Audiology may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Bright Audiology's health information practices or if you have a complaint, please contact the following person:

Bright Audiology
Stephanie Chilton – Practice Manager
1620 South Third Street Sanford, NC 27330
Telephone: 919-774-3277 Fax: 919-774-1643

INITIALS: _____

DATE: _____

Angela Bright-Pearson, Au.D
Lisa Barbour, AuD

BRIGHT AUDIOLOGY

1620 S Third St. Sanford, N. C. 27330
Phone: 919-774-3277 Fax: 919-774-1643

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:		Date of Birth:	
Guardian's Name		Social Security #:	
I request and authorize			to
release healthcare information of the patient named above to:			
	Name:	**BRIGHT AUDIOLOGY**	
♦ Healthcare information relating to the following treatment, condition, or dates:			
♦ All healthcare information			
♦ Yes ♦ No	I authorize the release of any records regarding medications, drug, alcohol, or mental health treatment to the person(s) listed above.		
Patient Signature:		Date Signed:	

I request and authorize **BRIGHT AUDIOLOGY** to release healthcare information of the patient named above to:

The Patients Primary Care Physician if requested ( ) To provide continuing treatment ( )

To obtain Insurance or Governmental benefits ( ) To help patient obtain monetary help thru T-Coil,

Care Credit, or Vocational Rehabilitation ( )

This request and authorization also applies to the provider: calling me with appointment reminders and other administrative operations.

I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice, I understand that BRIGHT AUDIOLOGY will consider requests, but does not have to agree to request for restrictions.

Patient signature _____ Date _____

Witness signature _____

THIS AUTHORIZATION EXPIRES 360 DAYS AFTER IT IS SIGNED !

MEDICAL HISTORY FORM

In order to help us assist you, please answer all questions on both pages thoroughly. Thank you.

EAR AND HEARING HISTORY: Please circle yes or no. If yes, please comment.

Have you experienced:

Ear Pain	Yes	No	_____
Drainage from the ear	Yes	No	_____
Chronic wax buildup	Yes	No	_____
Tinnitus (ringing/noises) in either ear	Yes	No	_____
Sudden hearing loss	Yes	No	_____
Fluctuating hearing loss	Yes	No	_____
Injury to the ear	Yes	No	_____
Surgery on either ear	Yes	No	_____
Ear Infections	Yes	No	_____
Ear Disease	Yes	No	_____

GENERAL HISTORY: Have you ever had the following:

Chemotherapy/Radiation	Yes	No	_____
Gentamycin, Vancomycin For severe infections	Yes	No	_____
Diabetes	Yes	No	_____
Arthritis/numbness in hands	Yes	No	_____
Head Injury	Yes	No	_____
Stroke	Yes	No	_____
Short-term memory problems	Yes	No	_____
High blood pressure	Yes	No	_____

Please list all of your current medications _____

Have you ever had your hearing tested? Last time _____ Where _____
What were the results? _____

Who else in your family has a hearing problem? _____

What type of loud noise have you been exposed to at work or home (e.g. factory work, hunting, etc.)
_____

If you have experienced episodes of dizziness or vertigo (spinning), please describe _____

Please check the one that best describes each situation:

	Almost Always (99%)	Half the Time (50%)	Occasionally (25%)	Never (1%)
I have trouble following a conversation when two or more people are talking at the same time. I have difficulty hearing over the phone	_____	_____	_____	_____
I have difficulty hearing women's/children's voices	_____	_____	_____	_____
I have trouble hearing conversation in noisy backgrounds, such as a restaurant or party.	_____	_____	_____	_____
I misunderstand words in a sentence and need to ask people to repeat themselves.	_____	_____	_____	_____
I attend church or meetings and cannot understand the speaker.	_____	_____	_____	_____
I avoid social situations because I cannot hear well and fear I'll make improper replies.	_____	_____	_____	_____
I have to strain to understand conversations.	_____	_____	_____	_____
I miss hearing common sounds such as the telephone or doorbell.	_____	_____	_____	_____
People get annoyed because I misunderstand what they say.	_____	_____	_____	_____
People tell me that the radio or tv is too loud.	_____	_____	_____	_____
Many people seem to mumble or do not speak clearly.	_____	_____	_____	_____
I have trouble hearing others when riding in a car.	_____	_____	_____	_____
I have difficulty hearing at the dinner table.	_____	_____	_____	_____

If you think you may be experiencing hearing loss:

When did you first notice a problem with hearing or understanding? _____

_____

What do you think caused your hearing problem? _____

_____

Did the problem occur suddenly or gradually? _____

What difficulty does your hearing cause you at home or at work? _____

_____

Which situations would you like to hear better in? _____

_____

What do you miss most about your hearing? _____

_____

HEARING AID HISTORY (skip this section if you've never worn a hearing aid)
Please circle:

I wear one / two hearing aid(s) in my left / right ear (s) All the time
Sometimes
Never

I have been pleased / dissatisfied with the aid (s) because _____

_____

Hearing aid information: Brand _____

Size _____

When purchased _____

Medication Log

updated 7/22/14

Name of Medication, including over the counter medications	What is medication taken for? Diabetes, thyroid, vertigo, etc.	Dosage	Frequency	Method for taking: oral, injection, etc