THE AUDIOLOGY & HEARING CENTER

boise hears™

PATIENT INTAKE PACKET

First Name: _____ **Last Name:** _____

Preferred Name: _____

Date of Birth (MM/DD/YYYY): _____ / _____ / _____ **Social Security #** _____

Street Address: _____

City: _____ **State:** _____ **ZIP:** _____

Cell Phone: _____ **Home Phone:** _____

Email Address: _____

Preferred Method of Contact: □ Phone □ Text □ Email

EMERGENCY CONTACT

Name: _____ **Relationship:** _____

Phone Number: _____

INSURANCE INFORMATION

Primary Care Provider: _____

Primary Insurance: _____ **Member ID:** _____

Secondary Insurance: _____ **Member ID:** _____

EMPLOYMENT INFORMATION

Occupation: _____ **Employer:** _____

HOW DID YOU HEAR ABOUT BOISE HEARS?

Who may we thank for referring you? _____

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Medical History

To provide you with the best hearing healthcare, please complete the following information.

Primary Care Physician: _____

CURRENT MEDICATIONS

Are you currently taking prescription medications? □ Yes □ No (name, dose, & frequency):

Medication #1 _____ Medication #2 _____

Medication #3 _____ Medication #4 _____

ALLERGIES

□ No Known Allergies □ Latex □ Silicone □ Adhesives	□ Medication(s): _____ □ Seasonal □ Other: _____

EAR HEALTH

Have you ever had ear surgery? □ Yes □ No. If yes, please explain:

_____

In the past six months, have you experienced any of the following?

□ Ear Pain □ Ear Drainage □ Ear Fullness or Pressure □ Sudden Hearing Loss	□ Dizziness / Vertigo □ Frequent Ear Infections □ None of the Above

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Hearing History

REASON FOR TODAY'S VISIT: (Check all that apply.)

□ Hearing Difficulty □ Hearing Test □ Hearing Aid Consultation □ Hearing Aid Check / Cleaning	□ Tinnitus (Ringing in the Ears) □ Earwax Removal □ Hearing Protection □ Other: _____

YOUR HEARING: When did you first notice difficulty hearing?

□ 1–3 years ago	□ More than 3 years ago

PREVIOUS HEARING CARE- Have you ever had a hearing evaluation? □ Yes □ No

Approximate Date: _____ Where: _____

Have you ever worn hearing aids? □ Right Ear □ Left Ear □ Both Ears

Brand: _____ How many years have you worn hearing aids? _____

TINNITUS (RINGING IN THE EARS)-Do you experience ringing, buzzing, humming, or other sounds in your ears?

□ Never □ Occasionally □ Frequently □ Constantly **If yes, which ear?** □ Right □ Left □ Both

NOISE EXPOSURE- If yes, please check all that apply:

□ Military □ Construction □ Emergency Services	□ Farming □ Factory / Industrial □ Music	□ Firearms / Hunting □ Power Tools □ Motorcycles

Patient Information Statement & Consent

Thank you for choosing **Boise Hears The Audiology & Hearing Center**. Our goal is to provide exceptional hearing healthcare through comprehensive evaluations, personalized treatment recommendations, and ongoing support. This page explains the services you may receive and requests your consent to proceed.

AUDIOLOGIC EVALUATION- I understand that today's appointment may include one or more of the following: Hearing Evaluation, Hearing Aid Programming / Verification, Hearing Aid Cleaning or Maintenance, Cerumen (Earwax) Management Screening, Hearing Protection Consultation, Speech Understanding Testing, Otoacoustic Emissions (OAE) or Hearing Aid Evaluation.

RECOMMENDATIONS- I understand that following my evaluation, my provider may recommend:

- Additional medical evaluation or referral, Hearing aids or assistive listening devices, Hearing protection devices Follow-up testing, Ongoing hearing healthcare services. I understand that recommendations are based on my hearing test results, communication needs, lifestyle, and professional clinical judgment.

EAR IMPRESSIONS- If ear impressions are needed for custom hearing aids, earmolds, hearing protection, or other devices, I understand that:

- Ear impressions are generally safe and routinely performed, Minor discomfort or temporary fullness may occur, Rare complications may include irritation or injury to the ear canal or eardrum. I will notify my provider of any history of ear surgery, drainage, pain, or perforated eardrums before impressions are taken.

PATIENT ACKNOWLEDGEMENT- By signing below, I acknowledge that:

□ I have provided accurate and complete medical and hearing history information.

□ I understand the purpose of today's evaluation and services.

□ I have had the opportunity to ask questions regarding my hearing care.

□ I consent to the recommended audiologic evaluation and related services.

□ I understand that I may decline any recommended service at any time.

Patient Signature: _____ Date: _____

HIPAA Notice of Privacy Practices & Acknowledgement

Boise Hears | The Audiology & Hearing Center is committed to protecting the privacy and confidentiality of your personal health information (PHI) in accordance with HIPAA. This notice explains how your information may be used and disclosed, your rights, and our responsibilities. A complete copy of our **Notice of Privacy Practices** is available upon request and on our website.

HOW WE MAY USE OR SHARE YOUR HEALTH INFORMATION

Treatment — to provide hearing evaluations, hearing aid services, hearing protection, follow-up care, referrals, and coordination with other providers.

Payment — to obtain insurance benefits, process claims, collect payment, and communicate with your insurance carrier regarding covered services.

Healthcare Operations — to improve patient care, maintain quality assurance, conduct staff training, comply with legal requirements, and operate our practice efficiently.

YOUR RIGHTS. As our patient, you have the right to:

□ Receive a copy of our complete Notice of Privacy Practices

□ Request restrictions on certain uses or disclosures of your health information

□ Request confidential communications

□ Inspect and obtain a copy of your medical records (subject to applicable laws)

□ Request corrections to your medical record

□ Receive an accounting of certain disclosures of your health information

□ File a complaint if you believe your privacy rights have been violated

PATIENT ACKNOWLEDGEMENT I acknowledge that I have been offered a copy of Boise Hears' Notice of Privacy Practices and understand that it explains how my protected health information may be used and disclosed. I understand that I may request a copy at any time.

Patient Signature: _____ Date: _____

Financial Policy & Patient Agreement

Thank you for choosing **Boise Hears | The Audiology & Hearing Center**. We are committed to providing exceptional hearing healthcare while helping you understand your financial responsibilities. Please review the following policies carefully.

INSURANCE BENEFITS- As a courtesy, Boise Hears will verify your insurance benefits and submit claims on your behalf whenever possible. Please understand:

- Insurance coverage is determined solely by your insurance carrier.
- Verification of benefits is not a guarantee of payment.
- Any deductible, copayment, coinsurance, or non-covered service is the patient's responsibility.
- The patient is responsible for all charges not paid by insurance.

PAYMENT POLICY/HEARING AIDS & CUSTOM DEVICES- Hearing aids, custom earmolds, hearing protection, and other custom-manufactured devices require payment according to the purchase agreement provided at the time of fitting. Manufacturer warranties, trial periods, and return policies will be explained before your purchase.

MISSED APPOINTMENT POLICY- If you are unable to keep your appointment, we kindly request **at least 24 hours' notice** so we may offer that appointment time to another patient. Repeated missed appointments or late cancellations may result in a missed appointment fee.

RETURNED CHECKS- A fee may be assessed for returned checks in accordance with Idaho law.

ASSIGNMENT OF BENEFITS- I authorize payment of insurance benefits directly to **Boise Hears The Audiology & Hearing Center** for services rendered. I understand that I am financially responsible for any balance not covered by my insurance carrier.

PATIENT AGREEMENT- By signing below, I acknowledge that:

□ I have read and understand the Financial Policy.

□ I agree to be financially responsible for all services rendered.

□ I authorize the release of medical information necessary to process insurance claims.

□ I authorize payment of insurance benefits directly to Boise Hears when applicable.

Patient Signature: _____ Date: _____