New Patient Form

Welcome to Audiology Services of West Virginia! We strive to do our best to help you reconnect to your world and communicate with your friends and loved ones through hearing. **Please fill out this form completely.**

Full Name: _____ I prefer to be called: _____

DOB: _____/_____/_____ ☐ Male ☐ Female ☐ _____ SSN: _____-_____-_____

Address: _____ City/State_____

Cell Phone: _____ Home Phone: _____

Email Address: _____ Primary Care Physician: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Employer:_____ Marital Status: _____

For billing purposes, we must have the name, relation and DOB of the policyholder on your insurance card below:

Insurance: _____ Policyholder/Relation: _____ DOB: _____

Policyholder Address (if different than above address): _____

How did you hear about Audiology Services of West Virginia? _____

Patient Financial Agreement

- As a courtesy, we will be happy to bill your current insurance and co-insurance for services; however, all charges, regardless of insurance or insurance coverage, are the patient's responsibility. Our clinic contracts with most insurance companies. It is your responsibility to contact your insurance company prior to services to investigate in-network eligibility. Signing this document gives us permission to bill your insurance company for the services you receive.
- It is important to remember that your individual contract with your insurance company determines co-pays, deductibles, etc. and how your insurance will pay for covered services. We make every effort to bill each visit with the proper diagnosis and procedure codes per national billing and coding guidelines as well as requirements for each insurance company. Please understand that we cannot make exceptions to our coding practices due to federal and state legal compliance concerns, and we are unable to bill for services other than those documented in your medical records in our clinic.
- Health insurance is required prior to services being rendered. If no health insurance information is provided at the time of service, you may be denied services until your insurance information can be documented or you may opt to pay out-of-pocket for services. It is your responsibility to ensure that insurance information is up-to-date and in effect. If Insurance information provided to our clinic at the time of service is, at any time, found to be incorrect or not in effect, you will be billed for any services provided.
- You may opt at any time to pay out-of-pocket rates for services that are typically billed to insurance. Charges for services not covered by insurance are due at the time of service. If you have a question about whether services are covered or not, please ask prior to the administration of the service.
- It is important to strictly enforce this policy of financial obligation. All co-pay, self-pay, and other payments are due at the time of service and may be paid by cash, check, credit, or debit card. We will assess a $25 fee for returned checks due to insufficient funds. We also offer financing through several institutions. Please ask for more information about financing.
- Fees will be assessed for no-shows and cancellation of appointments without 24 hours prior notice for any office visit. These fees are the responsibility of the patient and cannot be filed with your insurance company. Cancellation messages may be left on the company answering machine for your convenience but must be 24 hours in advance to avoid fees.
- All charges are due within 30 days of the invoice date. Second notices will be sent if not paid on the due date. All charges not paid within 90 days will be processed by our collection agency.

Acknowledgement of Receipt of Notice of Privacy Practices

This company's Notice of Privacy Practices may be found online at www.hearwv.com or a hard copy can be printed if you notify our Patient Care Coordinator. I attest that I have been given the opportunity to receive a copy of this office's Privacy Practices or have been directed to a copy of these practices that may be accessed either in hard copy or electronic copy. I have read and understand the above information and agree to comply with these policies.

Signature: _____ Date: _____

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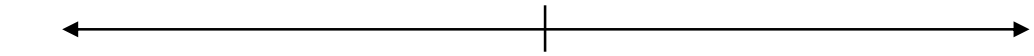
1. What is the most important issue for your provider to address today?

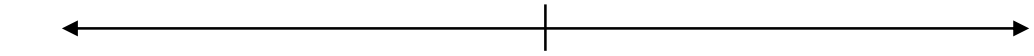
   ☐ Hearing Loss
   ☐ Tinnitus (noises in ears)
   ☐ Dizziness / Balance
   ☐ Other: _____

2. How important is it for you to improve your hearing, understanding, or communication with others?



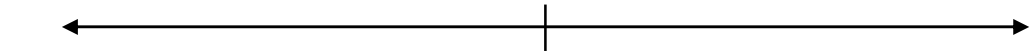
Not very important *Very important*

3. How motivated are you to treat a hearing loss if it is appropriate?



Not motivated *Very motivated*

4. How well do you think hearing aids will improve your hearing?



No improvement *Significant improvement*

5. What is your most important consideration regarding hearing aids?

   ☐ Size and the ability of others to not see the hearing aids.
   ☐ Improved ability to hear and understand speech.
   ☐ Improved ability to understand speech in noisy situations (restaurants, parties, etc.).
   ☐ Cost of hearing aids

6. Do you prefer hearing aids that:

   ☐ Are totally automatic so that you do not have to make adjustments to them
   ☐ Require you to make adjustments to the volume and programs as needed in different environments
   ☐ No preference

7. Please mark the top three situations where you would like to hear better:

   ☐ One-on-one conversations
   ☐ Groups
   ☐ Phone conversations
   ☐ Church
   ☐ Restaurants
   ☐ Other: _____

8. Do you experience dizziness or balance problems? ☐ Yes ☐ No

9. If yes, how would you describe your symptoms?

   ☐ Room spinning
   ☐ I am spinning
   ☐ Falling / Fear of falling
   ☐ Difficulty walking / staggering
   ☐ Feeling "off"
   ☐ Dizzy when sitting/standing
   ☐ Light-headed
   ☐ Veering to one side when walking
   ☐ Other: _____

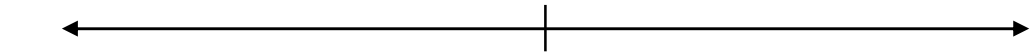
10. Do you experience ringing / noises in your ears (tinnitus)? ☐ Yes ☐ No

11. If yes, how would you describe your symptoms?

   ☐ Ringing
   ☐ Whistling
   ☐ Humming
   ☐ Different for each ear
   ☐ Static
   ☐ Other: _____

12. Does anything help to relieve your symptoms? ☐ No ☐ Yes: please describe: _____

13. How motivated are you to treat your tinnitus?



Not motivated *Very motivated*

14. Is there anything else you would like your provider to know: _____

_____

_____

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