ADVANCED
HEARING CARE

Dr. Julie P. Breton - Licensed Audiologist
Phone: 508.297.2444 | Fax: 508.297.1302
Email: info@advancedhearingcare.com

WELCOME

Thank you for contacting our practice, we look forward to meeting all your hearing needs.

This letter serves to confirm the appointment for _____

on _____ at _____.

PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR VISIT IN ORDER TO FILL OUT PAPERWORK.

WHAT TO BRING:

- Insurance Card
- Signed Financial Policy Form (Attached)
- Referral / Authorization from Primary Care Physician
- Primary Care Physician's Full Name, Address, and Telephone Number
- Pertinent Medical Records from Physicians you have seen for the same condition

***If patient is a minor, parent or legal guardian must be present.**

If you have any questions related to your appointment, please call. We look forward to seeing you!

Sincerely,

Advanced Hearing Care, Inc.

ADVANCED HEARING CARE *Advanced Hearing Care,Inc.*

508-297-2444

111 Belmont Street, Unit 1 - S. Easton, MA 02375

Patient Information Form

Last Name _____ First Name _____ MI _____

Birth Date _____ Sex _____ Home Phone # _____ Cell# _____

Social Security # _____ Email _____

Mailing Address (Street) _____

City _____ State _____ Zip Code _____

Do you currently wear a hearing aid(s) ? Yes _____ No _____

Family Relation's Name _____ Phone # _____

Primary Care Physician _____ Phone # _____

Address _____

Whom may we thank for referring you to our office? _____

Primary Ins. _____ Insurance ID# _____

Name of Policy Holder _____ Policy holders date of birth _____

Secondary Ins. _____ _____ Insurance ID# _____

Who is financially responsible for this visit? _____ Phone # _____

Does your insurance provide a hearing aid benefit? Yes _____ No _____

I authorize Advanced Hearing Care,Inc. to release information requested with regard to processing my claims.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Advanced Hearing Care,Inc. of any changes in my health status or in the above information.

Signature _____ Date _____

Parent Signature if Minor _____ Date _____

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HEARING HANDICAP INVENTORY FOR ADULTS (HHIA)

NAME:_____DATE:_____

INSTRUCTIONS: The purpose of this questionnaire is to identify the problems your hearing loss may be causing you. Check YES, SOMETIMES, or NO for each question. DO NOT skip a question if you avoid a situation because of your hearing problem. If you use a hearing aid, please answer the way you hear WITHOUT your aid.

		YES	SOME-TIMES	NO
S-1	Does a hearing problem cause you to use the phone less often than you would like?			
E-2	Does a hearing problem cause you to feel embarrassed when meeting new people?			
S-3	Does a hearing problem cause you to avoid groups of people?			
E-4	Does a hearing problem make you irritable?			
E-5	Does a hearing problem cause you to feel frustrated when talking to members of your family?			
S-6	Does a hearing problem cause you difficulty when attending a party?			
S-7	Does a hearing problem cause you difficulty hearing/understanding co-workers, clients, or customers?			
E-8	Do you feel handicapped by a hearing problem?			
S-9	Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?			
E-10	Does a hearing problem cause you to feel frustrated when talking to co-workers, clients, or customers?			
S-11	Does a hearing problem cause you difficulty in the movies or theater?			
E-12	Does a hearing problem cause you to be nervous?			
S-13	Does a hearing problem cause you to visit friends, relatives, or neighbors less often than you would like?			
E-14	Does a hearing problem caue you to have arguments with family members?			

		YES	SOME-TIMES	NO
S-15	Does a hearing problem cause you difficulty when listening to TV or radio?			
S-16	Does a hearing problem cause you to go shopping less often than you would like?			
E-17	Does any problem or difficulty with your hearing upset you at all?			
E-18	Does a hearing problem cause you to want to be by yourself?			
S-19	Does a hearing problem cause you to talk to family members less often than you would like?			
E-20	Do you feel that any difficulty with your hearing limits or hampers your personal or social life?			
S-21	Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?			
E-22	Does a hearing problem cause you to feel depressed?			
S-23	Does a hearing problem cause you to listen to TV or the radio less often than you would like?			
E-24	Does a hearing problem cause you to feel uncomfortable when talking to friends?			
E-25	Does a hearing problem cause you to feel left out when you are with a group of people?			

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Financial Policy

Thank you for allowing us to serve your hearing needs. As an accommodation to our patients, we have adopted the following payment policy, which will allow us to continue to provide the best care available. Should you have any questions or comments in this matter, our Practice Manager will be pleased to speak with you personally.

Payments are due at the time services are rendered. As a courtesy to our patients, we will allow other payment options within the conditions of this policy.

Cash	We accept cash, check (with picture identification) and Visa, MasterCard, American Express, Discover and Care Credit.
Insurance	Patients are responsible for payment of all services, however, as a courtesy to you we will submit claims directly to your insurance company and require only the insurance specified co-payment at the time of the visit. If payment has not been received from your insurance company within 60 days, you will be responsible to pay for the remaining balance promptly and in full. If your insurance plan requires a referral or authorization from your Primary Care Physician and one is not presented or available at the time of the visit, you will be asked to sign a waiver or you may choose to reschedule the appointment.
Returned Checks	A fee of $35.00 will be charged for all returned checks.

I have read, understood and agree with the above Financial Policy.

Signature _____ **Date** _____

Advanced Hearing Care, Inc.

111 Belmont Street, Unit 1
South Easton, MA 02375
508-297-2444

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

□ By checking this box and signing below, I acknowledge that I received a copy of Advanced Hearing Care, Inc.'s Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

_____ _____

Printed name of patient or personal representative Date

_____ _____

Signature of patient or personal representative Date