

HILL COUNTRY AUDIOLOGY SERVICE

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NOTICE OF PRIVACY PRACTICES (HIPAA)

Purpose: This Privacy Notice is required by the Privacy Regulations stemming from the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This Privacy Notice explains to you, a patient of this practice, how your medical information may be used and disclosed, and how you can get access to your medical information.

1. OUR COMMITMENT TO YOU REGARDING MEDICAL INFORMATION

This practice is determined to protect the privacy of your medical information. In order to provide you with quality care and service, as well as comply with the law, we must create a medical record for you and document the care and services you receive at this practice. Federal law requires us to ensure the confidentiality of your medical record. This notice will explain to you which circumstances require us to use or disclose your medical information. We also describe your rights, as well as our obligations, regarding the use and disclosure of medical information.

2. WHAT THE LAW REQUIRES US TO DO

The Federal Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We have the right to:

1. Change our privacy practices and terms of this notice at any time, provided that the law permits the change.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the change.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

Following is a description of the different circumstances that may require this practice to use or disclose your medical information. For any of these circumstances, you can submit a written request restricting our use or disclosure of your medical information for treatment, payment, or healthcare operations. You may also request, in writing, that we only disclose your medical information to certain individuals responsible for your care, or the payment for your care. Legally, we are not required to agree to your request. If we do agree to honor the written request, we then must abide by our agreement unless in those situations required by law, in emergencies, or when information is necessary to treat you. If you wish to revoke any previously written request, you may do so in writing.

4. ACKNOWLEDGMENT FORM

*** To be kept of file at Hill Country Audiology Service - please sign and return to Receptionist ***

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____

Signature: _____ Date: _____

5. PATIENT INFORMATION RELEASE

I, _____ give permission for the following person(s) to have access to my medical records from Hill Country Audiology Service.

NAME	RELATIONSHIP TO PATIENT
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature: _____ Date: _____

Patient Name: _____

Date: _____

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Doctors of Audiology

Hearing Loss Questionnaire

1. Do you have hearing difficulties? Yes No Unsure

When did it begin/first noticed? _____ Unsure

In both ears? Right ear only? Left ear only? Unsure

Do you feel it is progressively getting worse? Yes No Unsure

Rapidly Slowly Unsure

Who notices your hearing difficulties? Self Spouse Family Friends

What do you think caused your hearing difficulties? _____

2. Do you hear more clearly out of one ear than the other? Yes No

If so, which one is best? Right Left Unsure

3. Does your hearing fluctuate? Yes No Unsure

If so, In both ears? Right ear only? Left ear only? Unsure

4. Have you ever had your hearing tested? Yes No

If so, when was the last time? _____

5. How do you perceive your hearing on a scale from 1 to 10?

1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Poor		Fair		Good		Excellent		

6. Do you notice tinnitus (noises) in your ears? Yes No

If so, which in ear do you notice the tinnitus? Both? Right only? Left only?

How would you describe the tinnitus? _____

Would you say the tinnitus is present all the time? just occasionally?

When present, does the level stay constant? or does it fluctuate?

Does there appear to be related symptoms? Yes No Explain _____

7. Do you have blood relatives (alive/deceased) with hearing loss? Yes No Unsure

Does this include: Mother? Father? Siblings? Grandparents?

Have any worn hearing devices? Yes No Unsure

Does there appear to be a genetic link of hearing loss? Yes No Unsure

8. Have you ever worn hearing aids or used an assistive listening device? Yes No

If so, what type? _____ Purchase Date: _____

Do you feel like you might need hearing aids? Yes No Unsure

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9. Do you currently experience any dizziness? Yes No Unsure

If so, is the dizziness constant? occurs in episodes?

If episodic, how long do the episodes last? Seconds Minutes Hours Days

If episodic, how long between episodes? Hours Days Weeks Months

Does changing body position tend to trigger the dizziness? Yes No Unsure

How would you best describe your dizziness? _____

Does the dizziness occur along with nausea? Yes No

Does the dizziness occur along with the presence/increase of tinnitus? Yes No

When did the dizziness begin/first noticed? _____ Unsure

Do you currently receive medical care for your dizziness? Yes No

10. Are you currently having any ear pain and/or drainage? Yes No Unsure

Are you currently experiencing an ear infection? Yes No Unsure

11. Do you have a history of ear infections? Yes No Unsure

As a child? As an adult? Lifelong?

12. Have you ever had surgery on your ears? Yes No Unsure

Explain: _____

13. Has there been any sudden change in your hearing in the last 90 days? Yes No

14. Do you have a history of cerumen (ear wax) build-up requiring removal? Yes No

15. Please list the medications you take on a daily basis: _____

16. Have you had any significant noise exposure during your lifetime? Yes No

Military Hunting/Shooting Industrial Noise Loud Music Power Tools

Was hearing protection used? Always Most of the time Sometimes Never

17. Have you had any of the following? (Check all that apply)

High blood pressure

Kidney disease

Cancer

Low blood pressure

Stroke

Radiation treatment

Cardiovascular problems

Diabetes

Chemotherapy treatment

Measles

Mumps

Meningitis

18. Do you have any other medical conditions what should be noted, particularly if it affects your hearing or balance? _____
