Date: New Patient Registration Update of Current Patient						
Social Security Number:						
Gender: Male Female						
Cell Phone:						
May we contact you via e-mail: ☐ YES ☐ NO						
Phone:						
Name of Spouse, if appl.:						
ring Physician:						
Status: Full-Time Part-time Retired						
Work Phone:						
(Complete if Different Than Above)						
Date of Birth: Social Security Number:						
umber:						
lumber:						
ationship to Patient:						
ationship to Patient: Relationship to Patient:						
ationship to Patient: Relationship to Patient: mber:						
ationship to Patient: Relationship to Patient: mber: Policy #:						
ationship to Patient: Relationship to Patient: mber: Policy #:						
ationship to Patient: Relationship to Patient: mber: Policy #: Relationship to Patient:						
ationship to Patient: Relationship to Patient: mber: Relationship to Patient: Relationship to Patient: Relationship to Patient: mber: Policy #: Policy #:						
ationship to Patient: Relationship to Patient: mber: Policy #: Relationship to Patient: nmber: Relationship to Patient: mber: nmber:						
ationship to Patient: Relationship to Patient: mber: Policy #: Relationship to Patient: Relationship to Patient: Policy #: Policy Policy #: Policy P						

HILL COUNTRY AUDIOLOGY SERVICE

Jeffrey G. Sirianni, AuD 703 Hill Country Drive, Suite 102

Eric M. Hicks, AuD Kerrville, TX 78028

Doctors of Audiology

Fellows, American Academy of Audiology Telephone: (830) 792-4060

Board Certified in Audiology Fax: (830) 792-5288

Vicky Khamsiry Email: hcaudio@ktc.com

Reception Services Website: www.hillcountryaudiology.com

Patient Care Coordinator

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.
- 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 Serv	ice - 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 permi my medical records from Hill Country Audiology So	ssion for the following person(s) to have access to ervice.
NAME	RELATIONSHIP TO PATIENT
Signature:	Date:

Pa	tient Name: Date:						
	Hill Country Audiology Service 703 Hill Country Drive, Suite 102 Kerrville, TX 78028 830-792-4060 Pediatric Questionnaire Jeffrey Sirianni, AuD Eric Hicks, AuD Doctors of Audiology						
1.	What is the reason for having this child tested? (Check all that apply)						
	☐ Failed hearing screening ☐ Chronic ear infections ☐ Suspected hearing loss						
	☐ Delayed speech development ☐ School requirement ☐ Unsure						
2.	Where was this child born?						
	What was the result of the newborn hearing screening?						
	Passed both ears Failed both ears Passed/Failed one ear Unsure						
If either or both ears failed, was this child rescreened? Yes No							
	What was the result of the rescreening?						
3.	3. Was there any gestational complications? No 🗌 Yes 📗 Explain:						
	Was this child born full term? or premature? (How many weeks premature?)						
	Was this child born vaginally? ☐ or via Caesarean section? ☐						
	Was there any complicatations during birth? No Tyes Explain:						
	Did this child have to spend any time in neonatal intensive care? No Yes How long:						
4.	Does this child have a history of nasal allergies (runny rose, congestion)? Yes \ No \						
	What has been the normal course of treatment?						
5.	Does this child have a history of chronic ear infections? Yes No Unsure						
	If yes, how many recent ear infections within the last 6 months?						
	What has been the normal course of treatment?						
Has ventilation tubes ever been suggested or recommended? Yes \ No \ Unsure _							
	Has ventilation tubes ever been placed? Yes No How many times?						
6.	Is there hearing loss on either side of the family? Mother: Yes \(\bigcap \) No \(\bigcap \) Unsure \(\bigcap \)						
	Father: Yes No Unsure						
7.	Does this child alert to environmental sounds (turning head, moving eyes)? Yes No						
	Does this child respond to his/her name when called upon from behind? Yes No						
	Does this child follow simple verbal instructions (ie. get shoes, come to table)? Yes \(\bigcap \) No \(\bigcap \)						
	Does this child appear to struggle in school according to teachers, grades? Yes No						
8.	Do this child have any other medical conditions what should be noted?						