BECKMAN AUDIOLOGY, PLLC

PEDIATRIC PATIENT HISTORY – DATED: _____

NAME: _____ BIRTHDATE: _____

MEDICAL HISTORY:

☐ YES ☐ NO Passed newborn hearing screening?

☐ YES ☐ NO Full term pregnancy ☐ YES ☐ NO NICU stay?

☐ YES ☐ NO Has child seen a doctor in the past six months? (Dr. _____)

☐ YES ☐ NO Has child seen a doctor specializing in diseases of the ear?

If yes, give name and date _____

☐ YES ☐ NO Other than newborn hearing screening, has child had hearing tested?

If yes, give approximate date_____ by whom _____

☐ YES ☐ NO Has child had any type of ear surgery?

If yes, type of surgery _____ (Dr. _____)

☐ YES ☐ NO Does child have any major health issues?

If yes, please describe: _____

_____

☐ YES ☐ NO Does child have a history of head injury?

If yes, please describe: _____

ABOUT THE EARS: Does child have any of the following symptoms?

☐ YES	☐ NO	Deformity of the ear	☐ YES	☐ NO	Hearing loss
☐ YES	☐ NO	Drainage from the ear	☐ YES	☐ NO	Dizziness
☐ YES	☐ NO	Sudden or rapid loss of hearing	☐ YES	☐ NO	Ear pain
☐ YES	☐ NO	Excessive cerumen (ear wax)	☐ YES	☐ NO	Tinnitus (ear noise)

ABOUT THE HEARING:

☐ YES ☐ NO Has child been exposed to loud noise levels? If yes, check any that apply:
☐ Hunting/shooting ☐ Proximity to an explosion ☐ Other _____

☐ YES ☐ NO Does child have a family history of hearing loss?

☐ YES ☐ NO Does child experience difficulty hearing/communicating? If yes, please explain

_____

When did you first notice a problem with child's hearing? _____

☐ YES ☐ NO Has child worn a hearing aid before? ☐ Right ☐ Left ☐ Both

Date acquired: _____ Audiologist's name: _____

BECKMAN AUDIOLOGY, PLLC

PEDIATRIC PATIENT INFORMATION FORM

Last Name _____ First Name _____ MI _____

Birth Date _____ Sex _____ Phone _____Alternate phone _____

Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Parent's Email Address _____

Whom may we contact in case of an emergency? _____

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

Primary Care Physician _____

Mother's Name _____ Birth Date _____

Address _____

Occupation _____ Employer _____

Father's Name _____ Birth Date _____

Address _____

Occupation _____ Employer _____

Primary Insurance _____ Insurance ID # _____

Name of Policy Holder _____ Policy holder's DOB _____

Secondary Insurance _____ Insurance ID# _____

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

I authorize BECKMAN AUDIOLOGY, PLLC to release information requested with the regard to processing my claims.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I hereby assign all medical benefits to which I am entitled, including Medicare, private insurance and other plans to: LINDSAY SHAFER, AUD. or BECKMAN AUDIOLOGY, PLLC. This assignment will remain in effect until revoked by me in writing. 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 BECKMAN AUDIOLOGY, PLLC of any changes in my health status or in the above information.

Signature _____ Date _____

Parent Signature _____ Date _____

BECKMAN AUDIOLOGY, PLLC

CONFIDENTIALITY FORM

I, _____ give Dr. Lindsay Shafer, permission to discuss information regarding my patient care with the following:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Please print the address where you would like your correspondence from our office sent if other than your home address: _____

I give permission for the office to call my:

(_____) _____ Home phone ☐ YES ☐ NO

(_____) _____ Cell phone ☐ YES ☐ NO

(_____) _____ Alternate phone ☐ YES ☐ NO

Can a confidential message be left on your answering machine or voicemail? ☐ YES ☐ NO

I am fully aware that a cell phone is not a secure and private line.

I am fully aware my health information will be transmitted by electronic transmission and/or fax transmittal.

Signature _____ Date _____

Responsible Party _____ Date _____

BECKMAN AUDIOLOGY, PLLC

MEDICATION LIST

Please be sure to include all over the counter medications, supplements, vitamins, etc

Last Name _____ First Name _____ Birth Date _____

Allergies _____

_____

MEDICATION	DOSE	ROUTE	FREQUENCY	PRESCRIBED BY:

BECKMAN AUDIOLOGY, PLLC

HIPAA NOTICE OF PRIVACY PRACTICES

BECKMAN AUDIOLOGY, PLLC
2501 JIMMY JOHNSON BLVD., SUITE 306 | PORT ARTHUR, TEXAS 77640 | 409.722.3400

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: You protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining prior approval for testing or hearing aids may require that your relevant protected health information be disclosed to the health plan for approval.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when Dr. Shafer is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 409-722-3400.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature _____ Print Name _____ Date _____