Audiology
New Patient Forms

Please do not mail or fax this form.
Bring it with you to your appointment.

Referring Physician: _____

Reason for today's visit: _____

.

Patient Name: _____

Address: _____
Street **City** **State** **ZIP Code**

Email address: _____

Home phone: (_____) _____ **Cell phone**: (_____) _____

Date of Birth: _____ **Sex**: M / F **Marital status:** _____

Social Security #: _____ **Driver License #:**_____

Student: Y / N **If yes:** Full- or Part-time **Are you Hispanic or Latino:** Y / N

Circle one or more of the following groups in which you consider yourself to be a member:

American Indian or Alaska Native Black or African American Native Hawaiian or Pacific Islander

Asian White or Caucasian Unknown Prefer not to respond

Languages Spoken: English Spanish Other: _____

Occupation: _____

Employer: _____

Address: _____
Street **City** **State** **ZIP Code**

Phone: (_____) _____ **Extension:** _____

Emergency Contact: _____

Relationship to patient:_____

Primary phone: (_____) _____ **Alternate phone**: (_____) _____

Address: _____
Street **City** **State** **ZIP Code**

Primary Insurance Company: _____

Claims Address: _____
Street City State ZIP Code

Name of Insured: _____ **ID # of Insured:** _____

Group # of Insured: _____ **Relationship to Insured**: _____

Date of Birth of Insured: _____ **Social Security # of Insured:** _____

Secondary Insurance Company: _____

Claims Address: _____
Street City State ZIP Code

Name of Insured: _____ **ID # of Insured**: _____

Group # of Insured: _____ **Relationship to Insured**: _____

Date of Birth of Insured: _____ **Social Security # of Insured**: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date: _____ **Signature:** _____

I hereby authorize LoCicero Health to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made to LoCicero Medical Group or to the party who accepts assignment.

I certify the information I have provided with regard to my insurance is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may only be revoked by either me or my insurance company in writing.

Date: _____ **Signature:** _____

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that I will be responsible for payment of any allowable charge that my insurance coverage does not pay. I also understand that I will be responsible for services rendered that are not considered a covered benefit by my insurance company.

Date: _____ **Signature:**

_____

LoCicero Hearing

REGISTRATION FOR THE PATIENT PORTAL

LoCicero Health provides internet-based services offering a secure, private channel for healthcare consultation communications with your physician, personal medical information storage, online healthcare information, and related products, services and content.

You may access the secure Patient Portal at **lociceromedicalgroup.com/my-lmg/patient-portal**

We are excited to offer our patients this service and believe that this means of communication will enhance your relationship with our practice.

Please ask the front office staff for your login information.

For office use only:

Username: _____

Temporary Password: _____
(This password will expire within 24 hours)

PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida Statutes, please answer the following questions.

Declaration to Decline Life-Prolonging Procedure (LIVING WILL)

( ) I HAVE MADE SUCH A DECLARATION.

( ) I HAVE **NOT** MADE SUCH A DECLARATION.

Health Care Surrogate

( ) I HAVE DESIGNATED A HEALTH CARE SURROGATE.

( ) I HAVE **NOT** DESIGNATED A HEALTH CARE SURROGATE.

Durable Power of Attorney

( ) I HAVE APPOINTED A DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS.

( ) I HAVE **NOT** APPOINTED A DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS.

I have been provided with information regarding the PATIENT SELF DETERMINATION ACT.

Signature of Patient or Representative Date

I have been provided with information regarding the PATIENT SELF DETERMINATION ACT, but decline to answer the above questions.

Signature of Patient or Representative Date

YEARLY RECONFIRMATION

I acknowledge that this information remains accurate.

Signature of Patient Date	Signature of Patient Date
Signature of Patient Date	Signature of Patient Date
Signature of Patient Date	Signature of Patient Date

LoCicero Hearing

Audiology Case History

Name: _____ **Date**: _____

Ear/Hearing History

What is the reason for your visit today? _____

_____

What do you think caused your symptoms and/or hearing problem? _____

_____

Which situation(s) do you notice the most difficulty hearing in?

_____

_____

_____

If you are experiencing hearing difficulty, has the problem been sudden or gradual?

_____

Please circle "YES" or "NO" for the following questions.

1. Does one ear hear worse than the other? **YES NO**

   If yes, which is worse? **Right Left**
2. Does your hearing fluctuate? **YES NO**
3. Any drainage from your ear(s) within the past 90 days? **YES NO**
4. Any sudden or rapidly progressive hearing loss within the past 90 days? **YES NO**
5. Any pain, fullness or discomfort in your ear(s) within the past 90 days? **YES NO**
6. Do you have any noises in your ears (tinnitus)? **YES NO**
7. Have you experienced any dizziness or difficulty with balance? **YES NO**
8. Have you ever been in the military? **YES NO**
9. Do you currently wear a hearing aid and/or has a hearing aid been recommended? **YES NO**
10. Have you ever seen a doctor for wax removal? **YES NO**

Name: _____ **Date**: _____

For the following questions, if your answer is "YES" please explain.

11. Have you had any ear surgery? **YES** **NO**

    If yes, when, where, and by whom? _____

    _____

12. Is there a history of hearing loss in your immediate family? **YES** **NO**

    If yes, who? _____

13. Have you ever been exposed to loud noise from work or recreational activities? **YES** **NO**

    If yes, please describe the type of noise. _____

    _____

14. Have you been tested for hearing loss and/or dizziness before? **YES** **NO**

    If yes, when, where, and by whom? _____

    _____

Medical History (check all that apply)

_____ Heart Problems _____ High Blood Pressure _____ Diabetes

_____ Head Trauma _____ Pacemaker _____ Kidney Failure

_____ Stroke _____ Cancer _____ TMJ

_____ Bell's Palsy

_____ Other Diseases/Conditions: _____

_____

Patient/Guardian Signature: _____ **Date**: _____

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Addressed or Fax No.	Description of Disclosure	By Whom Disclosed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LoCicero Health
2605 W. Swann Ave., Suite 600
Tampa, FL 33609
Tele: (813) 876-7073
Fax: (813) 877-1277

PRIVATE PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

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

Name: _____ Date of Birth: _____

Signature: _____ Date: _____

PATIENT OF RECORD DISCLOSURES

In general, the HIPAA privacy rules give the individual the right to request a restriction on uses and disclosures of private information (PHI). The individual is also provided the right to request confidential communication of PHI, be made by alternative means, such as sending correspondence to the individual's office instead of home.

I wish to be contacted in the following many (check all that apply):

☐ Home Telephone: _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

☐ Work Telephone: _____
- ☐ O.K to leave message with detailed information

☐ Written Communication
- ☐ O.K. to mail to my home address.
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to: _____

☐ Other: _____

Name: _____ Date of Birth: _____

Signature: _____ Date: _____

The Privacy Rule generally requires healthcare providers to take responsible steps to limit the use of disclosure of PHI, and for the PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to the use made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will provide adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in emergency