

PATIENT GUIDE

Southeast Kentucky Audiology Services, INC wants you to be aware of the Federal Government rules and regulations that are in place to protect your health information. Southeast Kentucky Audiology Services, INC is committed to helping you understand these rules and regulations so that we can most effectively treat you. Southeast Kentucky Audiology Services, INC provides documents that tell you how information that may identify you and that relates to your audiological/health care will be used. Some of these documents must be signed by you to show you received and understand them and to enable the highest level of care by Southeast Kentucky Audiology Services, INC.

This pamphlet provides an overview of the documents you will receive from Southeast Kentucky Audiology Services, INC.

Notice of Privacy Practices

The Notice of Privacy Practices is a lengthy document that goes into detail to fully inform you about how your health information is used. In a nutshell, the Notice of Privacy Practices covers the following topics:

- How Southeast Kentucky Audiology Services, INC manages and protects your health information.
- How you can restrict certain uses and disclosures of your protected health information
- Your rights in requesting information about your protected health information; and
- Contact information if you have any questions or concerns regarding your protected health information.
- Southeast Kentucky Audiology Services, INC requests that you sign an acknowledgement that you received the Notice of Privacy Practices.

Authorization to Use and Disclosure

To assist Southeast Kentucky Audiology Services, INC in providing the best care possible and to communicate with those close to you and other health professionals that may be treating you, Southeast Kentucky Audiology Services, INC provides you a form to let us know who we can share your health information with.

Marketing Authorization

The marketing authorization form authorizes Southeast Kentucky Audiology Services, INC to contact you with various product and/or treatment options related to your audiological/health care. Southeast Kentucky Audiology Services, INC may receive compensation for these communications. The authorization form gives you the option of either:

- Authorizing all marketing communications.
- Requiring authorization for any one marketing communication.
- Prohibiting any marketing communication.

Questions/Comments

Please do not hesitate to ask us any questions you may have about your protected health information. You may contact Angie Farmer, at (606) 528-9993 or billing@sekyaudiology.com.

Office and Financial Policies

Thank you for choosing Southeast Kentucky Audiology Services, INC for your hearing healthcare needs. We are committed to you and your improved hearing and balance. We also want your experience with us to be a positive and productive one. To that end, we want to take this opportunity to inform our patients and their families of our payment policies. This knowledge will help you be better prepared for your appointment.

Southeast Kentucky Audiology Services, INC is a participating provider with many insurance carriers in the area. We can assist you in determining whether or not we are a participating provider for your insurance plan.

Insurance coverage is an agreement between you and your insurance carrier. We, as healthcare providers, just execute that agreement for you. As a result, it is your responsibility to determine whether or not you have out of network benefits (if Southeast Kentucky Audiology Services, INC is not a participating provider in your insurance plan), if you require prior authorization or a referral prior to services being provided or if audiology services and/or hearing aids are covered through your plan. It is important to gather this information prior to your appointment with us. Southeast Kentucky Audiology Services, INC cannot submit a claim to any insurance carrier if we do not have all required orders, referrals, or prior authorizations on file. They cannot be obtained after the service is provided. If you are unsure of your coverage specifics, please bring your member benefits handbook with you to the appointment.

Insurance carriers do not cover, in full, all goods and services. While we will verify coverage specifics with your insurance carrier as needed, please understand that these are NOT a guarantee of coverage or payment. There may be situations where your insurance carrier does not cover the specific good or service you are requesting. Southeast Kentucky Audiology Services, INC commits to providing quality, professional hearing healthcare to all its patients, regardless of their circumstance. When required and possible, we will work to offer an item or service that is within the limits of your insurance coverage.

It is very important that you inform us within 24 hours of your appointment if you need to cancel or reschedule. While we realize that emergencies do occur, Southeast Kentucky Audiology Services, INC reserves the right to charge a \$25 cancellation fee for all no-show appointments or appointments cancelled with less than a 24 hour notice.

We understand that sometimes you may be running late to your appointment. Unfortunately, we have patients scheduled throughout the day and may not be able to see you if you arrive more than 15 minutes after your scheduled appointment time. We will try to accommodate you if time allows. Otherwise, we will need for you come back later in the day if a later appointment is available or reschedule to another date and time.

Payment in full is due at the time the services are provided. You are responsible to pay all out of pocket expenses, such as co-pays, co-insurance and deductibles on the date the service is provided. All hearing aid related charges must be paid on the date you take possession of the aid, accessory or supply.

Southeast Kentucky Audiology Services, INC accepts payment in the form of cash, checks, American Express, Visa, MasterCard, and Discover. We also offer a third-party credit program through Care Credit. There will be a \$30 fee for all bounced or returned checks.

It is also the policy of Southeast Kentucky Audiology Services, INC that we maintain a credit card number on file. This allows us to bill you for an outstanding balance that is not collected within 120 days of the date you were initially billed, while continuing to provide you with care. We will not bill any charge to your credit card without first informing you of this in writing. You then have the right to use an alternate form of payment if you so choose.

It is important that each patient accepts and meets their financial obligations to this practice. Otherwise, we will be unable to provide care to any of our patients. Southeast Kentucky Audiology Services, INC reserves the right, following 120 days of the initial invoice date, to forward all outstanding balances to either a third-party collection agency and/or small claims court. We also reserve the right to discontinue care or service to patients who have not met their financial obligations to us.

Patient Signature _____

Date: _____



Southeast Kentucky

AUDIOLOGY

Better Hearing Begins Here

ADULT CASE HISTORY

Name: _____
 Birthdate: _____

Today's Date: _____
 Age: _____

GENERAL HISTORY

What is your primary reason for coming in today? _____

Have you ever had a hearing evaluation before? Yes No

If you suspect a hearing loss, do you feel the onset was Gradual Sudden Fluctuating

Is the cause of your hearing loss related to Aging Noise Accident Illness

Were you in the military? Yes No

Do you or have you ever shot guns? Yes No

Have you worked in a factory or coal mines? Yes No

In which ear do you hear the best? Right Left Same in both ears

Does anyone in your family have a hearing loss? Yes No

MEDICAL HISTORY

Have you had earaches or drainage from your ears in the past 90 days? Yes No

Have you ever had medical/surgical treatment for your ears? Yes No

Do you ever experience balance issues, dizziness, lightheadedness, or falls? Yes No

Have you ever had a head injury? Yes No

Do you experience tinnitus? (i.e. ringing, buzzing, humming, roaring) Yes No

Do you have routine MRI's? Yes No

Please list all major surgeries including type of surgery, who performed the surgery, and when the surgery was performed:

Please list any medications (prescription, over the counter, vitamins, and supplements) you are taking or have taken in the past year including amount and frequency:

Have you been diagnosed with any of the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes Type II | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Bell's Palsy | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Fevers | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Concussion/Skull Fracture | <input type="checkbox"/> HIV | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Dementia/Alzheimer's | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Tuberculosis |

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

Patient Name: _____

Date of Birth: _____

Address: _____

City/State/Zip _____

Social Security #: _____

Phone #: _____

I acknowledge that I received a copy of Southeast Kentucky Audiology Services, INC's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, the website (if applicable) and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

- This Notice informs me how Southeast Kentucky Audiology Services, INC will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Southeast Kentucky Audiology Services, INC may use and share my health information for other than treatment, payment, and health care operations.
- Southeast Kentucky Audiology Services, INC will also use and share my health information as required/permitted by law.

Printed name of patient or personal representative

Date

Signature of patient or personal representative

Date

**AUTHORIZATION TO USE AND DISCLOSURE OF
HEALTH INFORMATION**

Patient Name: _____

Date of Birth: _____

Address: _____

City/State/Zip _____

Social Security #: _____

Phone #: _____

I request and authorize Southeast Kentucky Audiology Services, INC to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

I consent to Southeast Kentucky Audiology Services, INC releasing protected health as detailed below.

I prohibit Southeast Kentucky Audiology Services, INC from using and disclosing medical information to any person or entity other than required by HIPAA regulations.

My protected health information may be used or disclosed to the following:

For the Purpose of:

If you need assistance in completing the authorization form, please contact Angie Farmer, at billing@sekyaudiology.com.

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Southeast Kentucky Audiology Services, INC.

I understand that this authorization is in effect until the revocation section of this form is signed or until written notice of revocation is received. I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Southeast Kentucky Audiology Services, INC.

I authorize Southeast Kentucky Audiology Services, INC's use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Southeast Kentucky Audiology Services, INC cannot condition my treatment, services, etc... on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

Printed name of patient or personal representative

Date

Signature of patient or personal representative

Date

EXPIRATION/REVOCAION SECTION

FOR OFFICE USE

Expiration: This authorization will expire on (must choose one):

One year from the date it is signed

Other (insert date or event): _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.

I hereby revoke this authorization.

Printed name of patient or personal representative

Date

Signature of patient or personal representative

Date

AUTHORIZATION AND RELEASE FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR MARKETING

Patient Name: _____

Date of Birth: _____

Address: _____

City/State/Zip _____

Social Security #: _____

Phone #: _____

I authorize Southeast Kentucky Audiology Services, INC to use/disclose my protected health information for marketing related to audiological/health-related products or services. I understand that Southeast Kentucky Audiology Services, INC or its business associates may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described.

I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

I Authorize Southeast Kentucky Audiology Services, INC to use and disclose medical information for any and all marketing purposes and understand that Southeast Kentucky Audiology Services, INC or its business associate may receive financial remuneration in exchange for making the marketing communication for on behalf of the third party whose product or service is being described. A list of anticipated and potential persons/class of persons/organizations to whom information may be disclosed is included below.

I request an Authorization form for each instance Southeast Kentucky Audiology Services, INC intends to use and disclose medical information for any marketing purposes and understand that Southeast Kentucky Audiology Services, INC or its business associate may receive financial remuneration in exchange for making the marketing communication or on behalf of the third party whose product or service is being described.

I prohibit Southeast Kentucky Audiology Services, INC from using and disclosing medical information for any marketing purposes.

A list of anticipated and/or potential persons/class of persons/organizations to whom information may be disclosed: Hearing Aid Manufacturers; FM Manufacturers; Ear Mold Manufacturers; Cochlear Implant Manufacturers; Tinnitus Device Manufacturers; Buying Groups; Buying Discount Groups; Pharmaceutical Companies; Battery Manufacturers; Consulting Groups

If you need assistance in completing the authorization form, please contact Angie Farmer, at billing@sekyaudiology.com.

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Southeast Kentucky Audiology Services, INC.

I understand that this authorization is in effect for the term set forth below or until the revocation section of this form is signed and received. I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to **Southeast Kentucky Audiology Services, INC**.

I authorize Southeast Kentucky Audiology Services, INC's use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Southeast Kentucky Audiology Services, INC cannot condition my treatment, services, etc... on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

Printed name of patient or personal representative

Date

Signature of patient or personal representative

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Printed name of patient or personal representative

Date

Signature of patient or personal representative

Date