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 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

PEDIATRIC CASE HISTORY

Patient Name: _____ Birthdate: _____

Parent/Guardian Name: _____ Today's Date: _____

Does the person completing this form have legal custody of the patient? ___ Yes ___ No

GENERAL HISTORY

What is your primary reason for coming in today? _____

Has your child ever had a hearing evaluation before? ___ Yes ___ No
If yes, when and what were the results? _____

Do you suspect your child has a hearing loss? ___ Yes ___ No ___ Unsure

Does your child startle to loud sounds? ___ Yes ___ No

Does your child respond to soft sounds (i.e. a knock at the door)? ___ Yes ___ No

Does your child respond to their name? ___ Yes ___ No ___ N/A

Is there a family history of permanent childhood hearing loss? ___ Yes ___ No ___ Unsure
If yes, who? _____

Is your child currently enrolled in any intervention services (i.e. First Steps)? ___ Yes ___ No
If yes, what services are being provided? _____

MEDICAL HISTORY

Where was your child born? _____

Was your child born prematurely? ___ Yes ___ No ___ Unsure
If yes, how early? _____

Were there any complications during the pregnancy or delivery? ___ Yes ___ No ___ Unsure
If yes, please explain. _____

Was your child jaundice at birth? ___ Yes ___ No ___ Unsure
If yes, how was it treated? _____

Was your child given oxygen at birth? ___ Yes ___ No ___ Unsure

Was your child given a newborn hearing screening? ___ Yes ___ No ___ Unsure
If yes, what were the results (i.e. pass/refer)? _____

Has your child spent any time in the NICU? ___ Yes ___ No ___ Unsure
If yes, please explain. _____

Has your child ever been given IV antibiotics? ___ Yes ___ No ___ Unsure

Has your child had any earaches? ___ Yes ___ No ___ Unsure
If yes, how many? _____

Has your child ever had medical/surgical treatment for their ears (i.e. tubes)? ___ Yes ___ No
If yes, please explain._____

Does your child ever experience balance issues? ___ Yes ___ No ___ N/A
If yes, please describe. _____

Does your child ever complain of hearing sounds in their ears? ___ Yes ___ No ___ N/A
If yes, please explain. _____

Please list all hospitalizations and/or major surgeries your child has had including type of surgery, who performed the surgery, and when the surgery was performed:

_____

_____

Please list any medications (prescription and/or non-prescription) your child is taking or has taken recently including amount and frequency:

_____

_____

Has your child been diagnosed with any of the following?

___ ADD/ADHD
___ Allergies
___ Asthma
___ Autism
___ Behavioral Problems
___ Cancer
___ Cerebral Palsy
___ Concussion/Skull Fracture
___ Deformities of the head, face, neck
___ Diabetes Type I
___ Diabetes Type II
___ Down Syndrome
___ Encephalitis
___ Fetal Alcohol Syndrome
___ Heart Problems
___ Herpes Simplex Virus
___ High Fever
___ Immune System Problems
___ Kidney/Bladder Problems
___ Low Birth Weight (less than 3 lbs.)
___ Measles
___ Meningitis
___ Muscle/Bone Problems
___ Mumps
___ Psychiatric Problems
___ Other, please explain. _____
___ Rheumatic Fever
___ RSV
___ Rubella
___ Scarlet Fever
___ Seizures
___ Skin Problems
___ Stomach Problems
___ Stroke
___ Tonsillitis/Strep Throat
___ Toxoplasmosis
___ Tuberculosis
___ Vision Problems

DEVELOPMENTAL HISTORY (Where applicable….)

At what age did your child begin babbling (i.e. “baba”, “mama”, “dada”)? _____

Can your child follow simple instructions (i.e. “where is the ball”)? ___ Yes ___ No ___ Unsure

At what age did your child say their first word? _____

Does your child have a speech and language delay? ___ Yes ___ No ___ Unsure
If yes, please explain. _____

Does your child have any other developmental delays? ___ Yes ___ No ___ Unsure
If yes, please explain. _____

_____ _____
Signature Date

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

FOR OFFICE USE

EXPIRATION/REVOCATION SECTION

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 Date

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☐ Other (insert date or event):_____

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I hereby revoke this authorization.

_____ _____

Printed name of patient or personal representative Date

_____ _____

Signature of patient or personal representative Date