CONCIERGE AUDIOLOGY
LAS VEGAS

10161 W. Park Run Dr, Ste 150
Las Vegas, NV 89145
Phone:702-706-4358
fax: : 702-725-2446

Service Hours:
By Appointment
info@conciergeaudiologylv.com

PATIENT INTAKE INFORMATION

Patient Name: _____ **Today's Date**:_____
Date of Birth: _____

Address: _____
_____
Home phone#: _____ **Cell phone#**: _____

Name of Guardian/Individual who is financially responsible/Power of Attorney and phone number or indicate "SELF": _____
Name of caregiver/family/friend who may assist with appointments and phone number:
_____
Preferred mode of communication for appointments (circle one):
home phone cellphone office caregiver other:_____
Email Address:_____
Permission to text/email/leave voicemails pertaining to appointments, etc (circle): YES/NO
Occupation (current/former):_____
Name of Primary Care Provider and phone #:_____
Referral Source/Name:_____
If you have experienced the following symptoms, please check all that apply:

- ☐ Ear pain
- ☐ Vertigo (spinning sensation)
- ☐ Sudden hearing loss last 90 days
- ☐ Ear drainage last 90 days
- ☐ Diabetes
- ☐ Noise exposure
- ☐ High blood pressure
- ☐ Vision impairment
- ☐ Arthritis
- ☐ Cardiovascular disease
- ☐ Dementia
- ☐ Allergies to acrylic, latex, or vinyl
- ☐ Seasonal allergies
- ☐ Family history of hearing loss
- ☐ Chronic ear infections
- ☐ Radiation treatment of head/neck
- ☐ Bleeding/blood clotting disorders
- ☐ Compromised immune system (HIV/Lupus/chemotherapy in last 6 mos)
- ☐ Tinnitus/Ringing in ear(s)
- ☐ Other ear/hearing related condition(s and or surgery:_____

If you experience tinnitus, check all that apply:

- ☐ Present in both ears
- ☐ Present in one ear (R/L?)
- ☐ Occasional
- ☐ Constant
- ☐ Pulsatile/drum-like

From a scale from 0 (not applicable) to 5 (extremely), how bothersome/disruptive is your tinnitus?:
_____

Please list medications: _____
Hearing tested before? What was the outcome? _____
Better ear (L/R) or not sure? _____ Do you use hearing aids? _____

What do you like/dislike about your current hearing aids? _____
Please describe where you experience difficulty hearing (restaurants, on the phone, tv, church, music, certain voices, etc.). _____
Please describe how your hearing loss has affected you: _____
Please list your goals, concerns, or questions here: _____
Are you interested in listening to audio from a device such as a cellphone, tablet, or TV through hearing aids?
Which devices would you be interested in?

- ☐ Iphone
- ☐ Ipad
- ☐ TV
- ☐ Android cellphone
- ☐ Android tablet
- ☐ Computer
- ☐ Caption Call
- ☐ Other

HIPPA- Authorization for the Use of Disclosure of Protected Health Information (PHI)

I consent to the use or disclosure of my Protected Health Information by Concierge Audiology Las Vegas (provider) for the purposes of diagnosing or providing hearing care and treatment of me. I understand that diagnosis or treatment of me by Provider may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health is used or disclosed to carry out hearing care and treatment. Provider is not required to agree to the restriction I may request. However, if Provider agrees to a restriction that I request, the restriction is binding on Provider. I have the right to revoke this consent, in writing, at any time, except to the extent that Provider has taken action on this consent. My “protected health information” (PHI) means health information including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or health care clearing house. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I consent to Provider’s use or disclosure of my PHI for purposes of delivering relevant communication to me.

Consent for Treatment

I voluntarily give my informed and valid consent to Concierge Audiology Las Vegas for the purposes of screening, assessment, consultation, and treatment. I understand the nature about the proposed service(s) offered and recommended to me, as well as any associated benefits and risks. I give Concierge Audiology Las Vegas my consent to carry out any type of services related to treatment, payment, and healthcare operations, call my home or other designated location and leave a message on voicemail in reference to any related services to the clinic (i.e. appointment reminder), mail to my home such as a financial bill or appt reminder card, email correspondence for all of the above similar items and purposes, to use and/or disclose protected health information about me to/with third parties involved in my care if need be. Such parties may include a physician, hospital, and/or insurance company. I may revoke this consent at any time. Should any change in guardianship or power of attorney occur, the clinic will be notified in a timely manner.

Please read carefully and sign below:

- I am ultimately responsible for the balance of my account for services rendered.
- I acknowledge I have read the HIPPA- Authorization for the Use of Disclosure of Protected Health Information (PHI) policy for this office.
- I have read and agree with the Consent for Treatment policy for this office.

I have read, understand and agree to the above information, certify this information is true and correct to the best of my knowledge and hereby give my permission to the practice to treat my concerns.

_____ _____

Patient/Responsible Party (Print) Patient/ Responsible Party (Signature)

_____

Date