HIPAA WAIVER

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 our office 773-777-3277. There is a copy of the policy displayed in our office near the front desk for your reference. **By signing this you have read and understand the waiver.**

Your signature below is only an acknowledgement that you received a notice of our Privacy Practices.

_____

Name of patient (please print

_____

Signature of Patient Date

_____

Signature of Patient Representative Date

_____

Reason Patient is unable to sign and needs a representative

_____

Relationship of Patient Representative to the Patient (please print)

Name Of Patient: _____Date Of Birth:_____Age:_____

Sex: M F Marital Status: Single Married Widow/Widower Other:_____

S.S. number_____ Name Of Spouse: _____

Address: _____City: _____St:_____Zip:_____

Contact Information: (Home)_____ - _____ - _____ (Work) _____ - _____ - _____

(Cell) _____ - _____ - _____ Email: _____

Occupation: _____ Insurance: _____

Primary Physician's Name: _____ Location/Phone: _____

Referring Physician's Name: _____ Location/Phone: _____

Emergency contact name and telephone number: _____

How Did You Hear About Us? Newspaper TV Mailing Physician Friend/Family Internet

(Check All That Apply) Other: _____

How satisfied are you with your hearing? 1 being the worst and 10 being best. 1 2 3 4 5 6 7 8 9 10

Please answer the following questions:

Are you experiencing hearing loss in one ear or both ears?	Right	Left	Both
Is this your first hearing test?	Yes	No	
Do you hear ringing or other sounds in your ears?	Yes	No	
Do you experience dizziness or lightheadedness?	Yes	No	
Have any relatives experienced hearing loss at a young age?	Yes	No	
Have you had surgery in one or both ears?	Yes	No	
Have you ever been treated with chemotherapy?	Yes	No	
Have you ever been exposed to high levels of noise?	Yes	No	
Do you have difficulty hearing in group situations?	Yes	No	
Have you ever worn or tried hearing aids?	Yes	No	

Do you suffer from any serious illnesses?_____

What listening environment do you struggle with and want to hear clearly in again?

_____