

**Midland Hearing Associates**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
(City) (State) (Zip)

Phone Number: Home \_\_\_\_\_

Work \_\_\_\_\_

Patient Social Security #: \_\_\_\_\_ Sex: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Parents or Spouse: \_\_\_\_\_

**INSURANCE INFORMATION:**

**\*\*We will need to make a copy of your card(s).\*\***

Primary Insurance Company: \_\_\_\_\_

Insured's Name (if different from patient): \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Insured's Name (if different from patient): \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Group #: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Yellow Pages \_\_\_\_\_ Radio \_\_\_\_\_ Doctor \_\_\_\_\_ Friend  
\_\_\_\_\_ Other: If "Other" where did you hear about us \_\_\_\_\_

Why are you being seen today: \_\_\_\_\_



**MIDLAND**  
Hearing Associates

**Patient Questionnaire**

- I. Please list the family members or other persons, if any, whom we may inform about your general hearing healthcare and diagnosis.

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- II. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

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- III. Please print the telephone number where you want to receive calls about your appointments, or information on your hearing healthcare/hearing aids if other than your home phone number:

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- IV. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?

YES \_\_\_\_\_ NO \_\_\_\_\_

- V. Can information be mailed to your home concerning our practice, newsletters regarding hearing healthcare, updates on technology, reminders for check ups and warranty renewals, or birthday/Christmas cards?

YES \_\_\_\_\_ NO \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ (guardian if under 18 years)

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

- **Our Patient Privacy Notice is available upon request.**

Michele B. Frazier, M.Ed.   Kenneth H. Johns, M.Aud.   Kelly A. Payne, Au.D.  
Three Richland Medical Park, Suite 130 • Columbia, SC 29203 • (803) 765-1919

*Certified and Licensed Audiologists*

**STANDARD AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO**

**MIDLAND HEARING ASSOCIATES, INC.  
ONE WELLNESS BOULEVARD, SUITE 108  
IRMO, SC 29063  
(803) 765-1919**

I authorize the release of any audiological information by Midland Hearing Associates, Inc. as necessary to process this claim. I request payment of medical benefits to Midland Hearing Associates, Inc. or their audiologists for services described on the attached claim form unless payment has been received. I understand that this information or a photostatic copy of the original shall be valid.

Signature \_\_\_\_\_

I authorize Midland Hearing Associates, Inc. to release any audiological information to the following people: (Please include physician's name, address, and/or phone number)

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Signature \_\_\_\_\_

- l. Food and Drug Administration: We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post-marketing surveillance information to enable product recalls, repairs or replacement.
- m. Workers compensation: In accordance with state law, we may disclose health information as required for processing a claim under worker's compensation.
- n. Public Health: Under South Carolina law, we may disclose your health information as required for processing a claim under worker's compensation.
- o. Correctional institution: If you are an inmate of a correctional institution, we may disclose to the institution or its agents health information that is needed for your health or the health and safety of other individuals.
- p. Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
- q. Health investigation: Federal and state laws make provisions for your health information to be released to appropriate health authorities provided that a member of our staff or business associates believes in good faith that we have engaged in unlawful conduct or have otherwise endangered one or more patients, workers or the public.
- r. Other disclosures: All other uses and disclosures of your information will only be made with your written authorization. If you have authorized us to use or disclose information about you, you may revoke this authorization at any time.

**Acknowledgement of Receipt of Privacy Practices**

This notice has been issued and considered effective on the date signed. We will keep this signed form on file for minimum of (6) years.

\_\_\_\_\_  
Signature of Patient/Representative and Relationship to Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Practice Representative

\_\_\_\_\_  
Date

Adapted from the following sources:

American Health Information Management Association  
Practice Brief - Notice of Information Practices, May, 2001

American Medical Association  
Field Guide to HIPAA Implementation  
Smith, Anderson, Blount, Dorsett, Mitchell and Jernigan, LLP

If you would like to obtain copy of our Notice of Privacy Practices please visit our website at [www.midlandhearing.com](http://www.midlandhearing.com) or send a written request to: Midland Hearing Associates, One Wellness Blvd. Suite 108 Irmo, SC 29063.



# MIDLAND

Hearing Associates

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### Understanding Your Medical Record/Health Information

As your healthcare provider, we will maintain a record of your visit that contains your symptoms, reports of examinations and test results, diagnoses, treatments, correspondence with other providers for future care or treatments.

### Your Health Information Rights

Your health record is the physical property of this practice; however the information it contains belongs to you. You have the following rights and we request that you notify the Privacy Officer of the Practice of your requests for any of these actions:

- Request Restrictions:** You have a right to request restrictions on the use of your information.
- Obtain a Paper Copy of this Notice:** You have a right to receive a paper copy of this Notice.
- Inspect and Copy:** You have a right to inspect and receive a copy of your health information. If you request a copy of your information, you may be charged a reasonable fee for photocopying, retrieval, labor, postage and supplies used.
- Amend:** You have the right to request that we amend your health information.
- Obtain an Accounting of Disclosures:** You have the right to request an accounting of certain disclosures of information that have been made about you. This listing includes those disclosures of your information other than treatment, payment or healthcare purposes and is within a specified period of up to six years. The first listing of disclosures is provided as a complimentary service to you, but you may be charged a reasonable fee for additional requests made within a twelve-month period.
- Request Communications of your Health Information:** You have the right to request that you receive communications regarding your information in a certain manner or at a certain location.
- Request Your Authorization for Disclosure:** You have the right to revoke an authorization for disclosure of information that was previously given.

### Our Responsibilities

Our practice is required to:

- Confidentiality:** Maintain the privacy of your health information.
- Provide a copy of this notice:** We will provide you with a copy of this notice of our legal duties and privacy practices with respect to the information we collect and maintain about you.
- Abide by the terms of this notice.**
- Unable to restrict:** We will notify you if we are unable to agree to a requested restriction of your information.
- Provide alternative means or alternative locations:** We will accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

Michale B. Frazier, M.Ed. Kenneth H. Johns, M.Aud. Kelly A. Payne, A.U.D.

*Certified and Licensed Audiologists*

One Wellness Boulevard  
Suite 108  
Irmo, SC 29033

(803) 765-1919

Three Richard Medical Park  
Suite 130  
Columbia, SC 29203

We reserve the right to change our privacy practices and to make new provisions effective for all protected health information we keep. Should our information practices change, we will notify you of these changes when you return to our office. We will not use or disclose your health information without your authorization, except as described in this notice.

### For More Information:

- If you have a question or would like additional information, you may contact our privacy officer.
- If you have a concern about the privacy of your information, you may contact our privacy officer. Your concerns will be responded to by our practice, but you may also file a complaint with the secretary of Health and Human Services in the U.S. Office of Civil Rights. The privacy officer will supply information about this procedure.

### Examples of Disclosures of Information:

- Treatment:**
  - We will use your health information for treatment purposes. As an example, information given to a nurse or physician will be recorded in your health record and used to determine your treatment goals, actions taken and clinical observations.
  - We will provide your other healthcare providers with copies of various reports that will help them to treat you for subsequent conditions that may arise.
- Payment:** A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatments and supplies used.
- Healthcare Operations:** The physicians and members of your healthcare team may use the information to evaluate the quality of care you received as well as the care received by others similar to you. This information will be used to improve the effectiveness of healthcare operations and services we provide.
- Business Associates:** There are some services provided through contracts with business associates. As an example, we contract with a company that provides information services for the computer system we operate. When these services are contracted, we may disclose your health information to this business associate so that they can perform the work we require. To protect your health information, the business associate must appropriately safeguard your information.
- Notification:** We may disclose information to notify or assist in notifying a family member, personal representative or other person responsible for your care, information about your general condition.
- Communication with Family:** We will use good judgment in disclosing to a family member or any other person your identify, health information relevant to that person's involvement in your care or payment related to your care.
- Research:** We will disclose only limited information to approved researchers that participate in research approved by our institutional review board. We will obtain a written authorization from you to disclose information for other research purposes.
- Funeral Directors:** We may disclose health information to funeral directors consistent with state law that allows them to carry out their duties.
- Organ Donation:** If you are an organ donor, we may disclose your information to organizations that help procure, bank or transport organs for tissue donation and transplantation purposes.
- Marketing:** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- Debt Collection:** We may contact you as part of a debt collection effort.