SOUTHWEST FLORIDA
Center for Hearing and Balance

7780 Cambridge Manor Place
Suite C
Fort Myers, FL 33907

239-332-0707

Patient Name_____ Male____ Female____

Marital Status (Circle one): M S D W Date of Birth_____ Age _____

Address_____City_____ State_____ Zip Code_____

Email address _____

Home Phone_____ Cell Phone _____ Cell Carrier _____

ABOUT YOUR EARS: Do you have any of these symptoms?

YES NO Deformity of the ear
YES NO Drainage from the ear
YES NO Sudden or rapid loss of hearing in the past 90 days
YES NO Acute or chronic dizziness
YES NO Pain in your ears
YES NO Noises, ringing, rushing or roaring in your ears
Which ear? Both Right Left Constantly Always

Which is your better ear? Same Right Left

ABOUT YOUR HEARING: Do you experience difficulty with the following?

YES NO Understanding conversation
YES NO Hearing in a crowd
YES NO Hearing on the telephone
YES NO Does your hearing fluctuate?
YES NO Have you ever had surgery on your ears?
YES NO Have you ever had chronic ear infections?
YES NO Do you have complaints from friends and family about your hearing?
If you feel you have a hearing problem, how long have you had it? _____
YES NO Does anyone in your family have hearing loss ?
(If so, what relationship? _____)
YES NO Have you ever worked in a loud place or had a loud recreational activity?
(Factory, construction, firearms, bands etc.)
YES NO Have you ever worn a hearing aid?
If yes, what have been your experiences? _____
YES NO If a hearing loss is found are you ready to take steps in rehabilitation?
YES NO We offer a special tests to evaluate how you hear in noise. It is not covered by insurance and will cost $15 out of pocket. Would you like the doctor to perform this test?

List Major Medical Problems: _____

List Medications you now take: _____

_____

Who can we thank for referring you to our practice? _____

Who may we discuss your test results and your condition with other than yourself? _____

_____

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OUR FINANCIAL POLICY

Thank you for choosing us to care for your hearing and balance needs. We are committed to your better hearing and resolution of your balance problems. Please understand that in order for us to maintain the highest level of care, payment must be received. Payment is considered part of your service. The following is a statement of our Financial Position and Policy, which we require that you read and sign prior to any service.

Sometimes offices offer "Free Hearing Tests". In general, free hearing tests are not really free; instead they are a lure to invite you into their offices so that they may sell you hearing aids. In many cases the evaluation is not complete enough to fit you with hearing aids and is only finished once you have committed to the purchase. If the test is complete, the cost of the test is wrapped up in the price of the devices you purchase. At Southwest Florida Center for Hearing and Balance we believe that the diagnostic tests we provide are of value in and of themselves whether you decide to follow our rehabilitation recommendations or not. We believe that the doctoral degree our clinicians hold affords our patients accurate, reliable diagnostic data followed by insightful interpretation and honest rehabilitation recommendations. A charge will be assessed for any diagnostic procedure we perform.

All patients must complete our information sheet and provide us with updated insurance information if applicable. We will accept assignment of many insurance benefits. However, we do require that any copays or deductibles be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We accept cash, checks, VISA, MasterCard and Discover.

MEDICARE (and most insurance companies) will pay for an initial hearing evaluation, a cochlear implant evaluation, mapping or testing, and videonystagmography (NVG or Balance Testing) when medically necessary **AND** referred by a medical doctor. If your visit is for one of these and you have an order from your doctor, *we can expect payment will be made through your insurance company.*

Medicare and many insurance companies *do not cover* a **routine hearing exam annually**, though your audiologist may recommend you have an evaluation to determine the current status of your hearing and to verify the current settings on your hearing aids are appropriate. In addition, if you are purchasing a hearing aid and an evaluation has not been completed within 6 months, Florida Law requires a new hearing exam to be completed prior to being fitted with new hearing aids. Therefore, if your exam is an annual exam, prescheduled after your hearing aids have been fit, or for the purpose of a new hearing aid fitting, you will be expected to pay at the time of service. The cost for a hearing exam is $125.

Medicare and many insurances also *do not cover* wax removal by an audiologist nor do they cover treatment for BPPV when performed by an audiologist, even though these things are well within the scope of an audiologist's practice. As a result those procedures when performed at Southwest Florida Center for Hearing and Balance will be out of pocket expenses, $65 for wax removal and $115 for BPPV treatment. Dr. Mercer will advise you before doing any treatment to allow you to choose if you want the service performed.

Not all cochlear implant services are covered by insurances; specifically, troubleshooting and counseling and instruction on how to use the device or its wireless components. Non reimbursed cochlear implant services will be charged $65 for each half hour of service.

Thank you for understanding our Financial Position and Policy. **Please let us know if you have questions or concerns.**

I have read and agree to adhere to the above financial policy.

X_____ Date_____

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Patient Name: _____

I hereby acknowledge that I have read this medical practice's notice of Privacy Practices (located in folder in waiting room).

Signed _____ Date _____

I wish to receive a copy of Notice of Privacy Policies NO ◯ YES ◯

If not signed by patient, indicate relationship:

- ◯ Parent or guardian
- ◯ Guardian or conservator of an incompetent patient
- ◯ Beneficiary or personal representative of deceased patient

For office use only

Signed and received by: _____

Date Acknowledgement refused: _____

Efforts to Obtain:

Reason for refusal: