Valleydale Hearing and Balance Center
244 Inverness Center Drive, Suite 100
Birmingham, Alabama 35242
Phone: 205-637-0731 Fax: 205-637-0733

Date: _____

PERSONAL INFORMATION:

Name: _____ ☐ MALE ☐ FEMALE
First M. Last

Street Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip Code: _____

Primary Ph #: _____ Alternate Ph #: _____ Email: _____

(Please circle one of the above to indicate your preferred method of contact.)

DOB: ____/____/_____ Age: _____ Marital Status: _____

Emergency Contact: _____
Phone:_____ Relationship to Patient: _____

EMPLOYMENT STATUS: ☐ Full Time ☐ Part Time ☐ Retired ☐ None

Employer: _____ Phone: ( ) _____-_____

MEDICAL DOCTOR INFORMATION:

Referring Physician: _____ Phone: ( ) _____ - _____

Primary Care Physician: _____ Phone: ( ) _____ - _____

INSURANCE INFORMATION:

PRIMARY Insurance: _____ Policy Holder Name: _____

Member ID: _____ Policy Holder DOB: _____

Group Number: _____ Relationship to Policy Holder: _____

SECONDARY Insurance: _____ Policy Holder Name: _____

Member ID: _____ Policy Holder DOB: _____

Group Number: _____ Relationship to Policy Holder: _____

OVER →

PLEASE STATE BRIEFLY THE NATURE OF YOUR PROBLEM: _____

_____

_____

PLEASE LIST MEDICATIONS YOU ARE TAKING: _____

_____

PLEASE NAME ANY MEDICATIONS YOU ARE ALLERGIC TO OR HAVE BEEN ADVISED NOT TO TAKE:

_____

_____

PLEASE LIST OPERATIONS YOU HAVE HAD: _____

_____

PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE HAD OR NOW HAVE:

☐ Heart Disease	☐ Glaucoma	☐ Stroke	☐ Nausea
☐ Artificial Joints	☐ Ulcer Disease	☐ Depression/Anxiety	☐ Cancer
☐ Back Problems	☐ Multiple Sclerosis	☐ Blood Disorders	☐ Asthma
☐ Epilepsy/Convulsions	☐ Neck Problems	☐ Emphysema / COPD	☐ Pacemaker
☐ Infection / Wounds	☐ Tuberculosis	☐ Arthritis	☐ Breathing Problems
☐ High Blood Pressure	☐ Parkinson's disease	☐ Ringing in ears	☐ Circulation Problems
☐ ***** *Diabetes*	***** *If yes, when were you diagnosed?*		***** *Age/Year* _____

AUTHORIZATION FOR TREATMENT

The patient/legal guardian authorizes The American Institute of Balance Affiliate Network staff to administer appropriate testing and/or treatment for the patient's diagnosis/rehabilitation. The patient/legal guardian agrees that no guarantee or assurance has been made as to the results that may be obtained from the services rendered.

SIGNATURE: _____ **Date:** _____

AUTHORIZATION FOR PAYMENT

I authorize Valleydale Hearing & Balance Center to file a claim to my insurer on my behalf for services provided at said facility. I understand that all medical benefits, copayments and deductibles, when applicable, will be issued directly to Valleydale Hearing & Balance Center.

SIGNATURE: _____ **Date:** _____

I have received the †**NOTICE OF PRIVACY PRACTICES** and have been offered an opportunity to review it.

(†See next page)

SIGNATURE: _____ **Date:** _____

Witness: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE TAKES EFFECT APRIL 14, 2003, AND WILL REMAIN IN EFFECT UNTIL WE REPLACE IT.
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY; THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

LAW REQUIRES US TO:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

WE HAVE THE RIGHT TO:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

NOTICE OF CHANGE TO PRIVACY PRACTICES:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and health care operation. For example:

Treatment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider providing treatment for you.

Payment: We may use and disclose your medical information for payment purposes.

Health Care Operations: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

On your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it, in writing, at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up medicine, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminder: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, emails, or letters.)

Disaster Relief: We may use or disclose your health information to a public or private authorized by law by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public benefit.

- As required by law;
- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employees regarding workers compensation or other similar programs;
- To health oversight agencies;
- In response to court and administrative order and other lawful processes;
- To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- To coroners, medical examiners, and funeral directors;
- To an organ procurement organization;
- To avert a serious threat to health or safety;
- In connection with certain research activities;
- To the military and federal officials for lawful intelligence, counterintelligence, and national security activities;
- To correctional institutions regarding inmates; and
- As authorized by state worker's compensation laws.

(Notice continued on next page)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions; you may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. Contact us using the information listed at the end of this notice for more information about fees.

Disclosure Accounting: You have a right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, and health care operations and other specified exceptions. If you request this accounting more than once in a 12 month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location of your request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLIANTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S Department of Health and Human Services. Upon request, we will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

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MEDICAL RECORDS RELEASE

Patient Name: _____ **Date of Birth:** _____
Last First M.I.

I (the undersigned) hereby authorize and/or request my medical records to be furnished as follows:

Valleydale Hearing & Balance Center may supply my medical records to the following **physicians**, other individuals/**family members,** and/or facilities. **(Please list those below)**

If you prefer not to list anyone, please cross through the lines above and sign/date the form where indicated below.

Comments:
_____
_____
_____

Patient Signature **Date**

Parent / Legal Guardian Date

Witness Date