PRESBYTERIAN EAR INSTITUTE
415 CEDAR ST SE
ALBUQUERQUE, NM 87106
(505) 224-7020 OFFICE

Patient Registration *(Please Print Clearly)* *TODAY'S DATE* ______________

Patient Name ____ Birth date ______________
Last Name First Name Middle Initial

Mailing Address: ______________________________ Phone ( ) ______________

City: ______________________________ State ________ Zip Code ______________

Physical Address (if different) ______________________________

Sex ☐ Male ☐ Female SS# _____/_____/______ Age______ ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Ethnicity (***Select all that apply***) ☐ Hispanic ☐ Black ☐ White ☐ Native American ☐ Asian ☐ Other

Email: ______________________________ Alternate Phone ( ) ______________

Employer______________________________ Employer Phone ( ) ______________

Who referred you? ______________________ Primary Care Physician ______________________

In case of emergency who should be notified? ______________________ Phone______________

Person Responsible for Account ______________________________

Parent/Guardian/Personal Representative Information *(Please Print)*

Name **(Parent 1)** ______________ DOB: ________ Name **(Parent 2)** ______________ DOB: ________

Relation to Patient______________________________ Phone ( ) ______________

Address if different from above______________________ Email______________________

City ______________________ State________ Zip Code ______________

Employer______________________ Employer Phone ________ Occupation______________

Primary Insurance *(Please Print Clearly)*

Insurance Company Name______________________________ Phone ( ) ______________

Member ID# ______________________________ Group # ______________

Insured's Name ______________________ DOB__________ SS#______/______/______

Secondary Insurance *Is Patient covered by Additional Insurance?* ☐ Yes ☐ No

Insurance Company Name______________________________ Phone ( ) ______________

Member ID# ______________________________ Group # ______________

Insured's Name ______________________ DOB__________ SS#______________

Signature, I consent to treatment and have supplied all information to the best of my knowledge.

______________________________ ______________
Signature of Patient, Parent, Guardian, or Personal Representative Date

☐ **No Changes** Signature:______________________ Date: ______________

☐ **No Changes** Signature:______________________ Date: ______________

☐ **No Changes** Signature:______________________ Date: ______________

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FAX ~ (505) 224-7023

MEDICAL RECORDS RELEASE / REQUEST FORM

THIS FORM ALLOWS PRESBYTERIAN EAR INSTITUTE TO SEND MEDICAL RECORDS TO THE REFERRING DOCTOR, AUDIOLOGIST, AS WELL AS OTHER PROFESSIONALS AS INDICATED BELOW.

PATIENT INFORMATION

PATIENT NAME: ______________________________ DATE OF BIRTH: ____/____/____

ADDRESS: ____

CITY: ____________________ STATE: ________ ZIP: __________

INFORMATION TO BE RELEASED

** PLEASE INDICATE SPECIFIC RECORDS TO BE RELEASED.*

____

____

____

PARTY RELEASING INFORMATION

FACILITY NAME: ____

FAX NUMBER: ____________________ ADDRESS: ______________________________

AUTHORIZATION

BY SIGNING BELOW, I HEREBY AUTHORIZE THE ABOVE FACILITY TO OBTAIN PERTINENT INFORMATION, INCLUDING MEDICAL, SOCIAL AND EDUCATIONAL AS NEEDED. IN ADDITION, I AUTHORIZE THAT A PHOTO COPY OF THIS AUTHORIZATION BE ACCEPTED WITH THE SAME AUTHENTICITY AS THIS ORIGINAL. ANY PERSON OR AGENCY RECEIVING THIS INFORMATION IS DIRECTED TO TREAT IT AS CONFIDENTIAL. THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME. THE DISCLOSED INFORMATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT. THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE IT WAS SIGNED.

____ ______/______/______

SIGNATURE OF PATIENT, GUARDIAN, OR PERSONAL REPRESENTATIVE — DATE

☐ **No Changes Signature:** ______________________ **Date:** ______________________

☐ **No Changes Signature:** ______________________ **Date:** ______________________

PRESBYTERIAN EAR INSTITUTE
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Welcome to PEI. Our goal is to provide you with quality medical care in a friendly, safe and caring environment. Although we take pride in the quality of our services, we know there is always room for improvement. If you have any suggestions or concerns related to your care of the service you receive, please request to speak with our office manager. PEI is committed to maintaining the very highest standards of ethics and integrity. We are committed to ensuring that all affairs are conducted in accordance with all applicable laws, rules, regulations policies and procedures.

FINANCIAL AGREEMENT

I, the undersigned patient/guardian/parent, assign directly to Presbyterian Ear Institute all benefits otherwise payable to me for services rendered. I also authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronic. I acknowledge that co-pays and deductibles are due at the time of treatment. I accept full financial responsibility for all charges not covered by insurance.

APPOINTMENT NON-COMPLIANCE CONTRACT

PEI understands that not showing and late cancellations for appointments sometimes cannot be helped. As soon as you are aware that you will be unable to keep your appointment, please notify the office immediately. Patients who no show or cancel with less than 24 hours notice of their scheduled appointment will be charged a $25.00 fee for which the patient, not the insurance company, is responsible. This fee must be paid in full before PEI will allow another appointment to be scheduled.

FACILITY AGREEMENT

Presbyterian ear institute (PEI) will make every attempt to make the wait comfortable, but we do insist that clients who are coming to Presbyterian Ear Institute for audiology testing (hearing tests), speech and language evaluation or therapy visits remain in the lobby while waiting for their provider. The provider will come to the lobby to accompany their client(s) to their office. **Guardians of minor clients must remain on Presbyterian Ear Institute property while the patient is being seen. No exceptions will be made.**

All patients/visitors to PEI must sign in at the front desk prior to any appointments.

Presbyterian ear institute (PEI) has several programs including a ***parent infant program***, ***speech and language therapy program***, and ***Presbyterian Ear Institute Oral School***. The school has a playground on site, as well as classrooms and a learning center. Due to insurance liability these areas are for enrolled students of Presbyterian Ear Institute and their families upon staff supervision only.

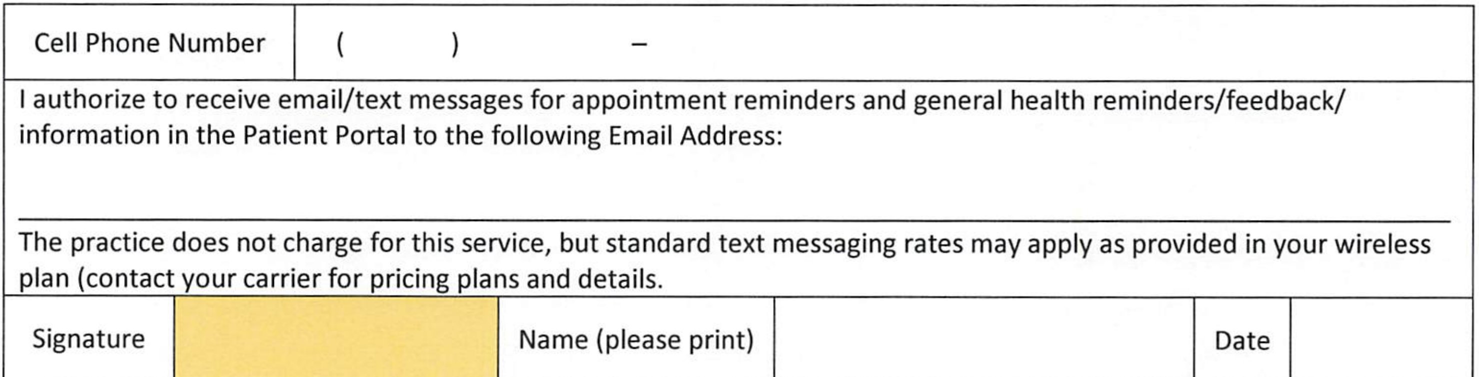
By signing below it is understood that all the above policies of Presbyterian Ear Institute will be followed.

______________________________	______________________________
PATIENT OR GUARDIAN (IF PATIENT IS MINOR)	DATE
______________________________	______________________________
PEI RECEPTIONIST	DATE

CONSENT TO EMAIL OR TEXT USAGE FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

__________ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information to the following Cell Phone number:



Cell Phone Number	( ) –				
I authorize to receive email/text messages for appointment reminders and general health reminders/feedback/ information in the Patient Portal to the following Email Address: ____					
The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details.					
Signature		Name (please print)		Date	

Presbyterian ear Institute

HIPAA PRIVACY POLICY

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY THE STUDENT HEALTH CENTER AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Please note: Our full HIPAA Privacy Policy is available at the front desk of our office and we can also provide our full HIPAA policy handout for your records upon your request. You can also access the full form on our website at peiabq.org/contact.

ACKNOWLEDGEMENT OF RECEIPT:
Federal law requires that we seek your acknowledgment of receipt of this Notice of Privacy Practices. Please sign below.

I acknowledge that I have received this Notice of Privacy Practices with an effective date of July 31, 2008, and that I understand that if I have any questions regarding this Notice, I may contact the Privacy Officer.

Signature: ______________________________ Date: ______________

Printed Name: ______________________________

Signature of Parent/Guardian(specify which):

______________________________________ Date: ______________

For Office Use Only

Signed Acknowledgment of Receipt received on ____________________.
Initials ________

Notice of Privacy Practices sent/delivered on ____________________.
Initials ________

Patient Refused or Failed to Acknowledge Receipt on ________________.
Initials ________

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AUDIOLOGY
Child Case History

Name: ______________________ DOB: ______________ Date: ____________

1. For what reason was this appointment arranged?
____
____

2. Who referred you to Presbyterian Ear Institute? ______________________

3. Has your child ever had a hearing test? ☐ Yes ☐ No
Where? ______________________
What were the results? ______________________

4. Did your child receive a hearing screen at birth? ☐ Yes ☐ No
What Hospital? ______________________
Did he/she pass in both ears? ☐ Yes ☐ No

5. Do you have any concerns about your child's hearing? ☐ Yes ☐ No

6. Does your child respond to sounds? ☐ Yes ☐ No

7. Does your child follow verbal directions? ☐ Yes ☐ No

8. Does anyone in the family (sis*ters, brothers, aunts, grandparents, etc.)*
have a hearing loss? If so who? ______________________ ☐ Yes ☐ No

Does any one in the family have a language/speech delay? ☐ Yes ☐ No
If so who? ______________________

9. Were there any complications during pregnancy or delivery? ☐ Yes ☐ No
Please explain: ______________________
____

10. Was any of the following present after your child's birth or during the first two months?

- ☐ Stayed in hospital after mother
- ☐ Birth weight less than 5 lbs.
- ☐ Did not respond to sounds or people
- ☐ Was in an incubator or isolette
- ☐ Difficulty breathing
- ☐ High fever
- ☐ Prematurity
- ☐ Poor weight gain
- ☐ Appeared yellow
- ☐ Infections at birth
- ☐ Physical deformities
- ☐ Other ______________________
Please describe ______________________
____

Adopted in part from ASHA

11. What is your child's general health? ☐ Good ☐ Average ☐ Poor

12 Is your child taking any medication now? ☐ Yes ☐ No
Please list all medications________________________________

13. Has your child ever been hospitalized? ☐ Yes ☐ No
Please explain: ________________________________

14. Has your child had any ear infections or other ear disorders? ☐ Yes ☐ No
How many episodes? ________________________________
When was their last ear infection? ________________________________

15. Has your child ever received tubes due to frequent ear infections? ☐ Yes ☐ No

16. Has your child had any ear surgery ☐ Yes ☐ No

17. What illnesses has your child had?

☐	High Fever	☐	Dizziness
☐	Convulsions	☐	Pneumonia
☐	Measles	☐	Heart problems
☐	Head or ear injury	☐	Rheumatic fever
☐	Encephalitis	☐	Allergies
☐	Meningitis	☐	Asthma
☐	Tonsillitis	☐	Other: ________________

18. Has you child ever received speech therapy? ☐ Yes ☐ No
If so where and how often? ________________________________

19. Do you have any concerns about your child's speech and language? ☐ Yes ☐ No
If yes, please explain________________________________

20. Do you have any concerns about your child's physical or mental development? ☐ Yes ☐ No

21. Do you believe your child has any learning problems? ☐ Yes ☐ No

22. Has your child ever received any special services? (***Physical therapy occupational therapy etc....***) ☐ Yes ☐ No
If so where and how often? ________________________________
____

23. If your child is under 3yrs of age, approximately how many words can your child say? ________________________________

24. What questions would you like to have answered as a result of today's hearing test?________________________________
____
____