445 Lenox Road, Ste. J, P.O. Box 1283, Brooklyn, NY, 11203
9015 5th Avenue, Lower Level, Brooklyn, NY, 11209
2204 Voorhies Avenue, Lower Level, Brooklyn, NY. 11235

Dr. John P. Weigand AUD PC.

LIBERTY HEARING CENTERS
DOCTORS OF AUDIOLOGY

REGISTRATION FORM

(Please Print)

Today's date:

Doctor:
Department:

Referring Doctor (if not primary):
Address:
Phone:

PCP:
Address:
Phone:

Service Location:

PATIENT INFORMATION

Patient's last name: First: Middle: ❒ Mr. ❒ Mrs. ❒ Miss ❒ Ms. Marital status: ❒ Sing ❒ Mar ❒ Div ❒ Sep ❒ Wid

Is this your legal name? If not, what is your legal name? ❒ Yes ❒ No

Former name?

Birth date: / /

Age:

Sex: ❒ M ❒ F

Street address:

P.O. Box:

City:

State:

Zip Code:

Social Security #:

Home phone: ( )

Cell phone: ( )

Email address:

Employer:

Occupation:

Employer phone: ( )

Chose office because/Referred to office by (please check one box): ❒ Dr. ❒ Insurance Plan ❒ Hospital ❒ Family/Friend ❒ Newspaper ❒ Close to home/work ❒ Telemarketing ❒ Online/Website ❒ Direct Mail ❒ Other/Walk Around

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card and Photo I.D. to the receptionist.)

Person responsible for bill: Birth date: / / Address (if different): Home phone: ( )

Is this person a patient here? ❒ Yes ❒ No

Occupation: Employer: Employer address: Employer phone: ( )

Is this patient covered by insurance? ❒ Yes ❒ No

Please indicate primary coverage: ❒ Insurance ❒ Workers' Comp ❒ No Fault ❒ Other ❒ Self Pay

Subscriber's name: Subscriber's S.S. #: Birth date: / / Group no.: Policy no.: Co-payment $

Patient's relationship to subscriber: ❒ Self ❒ Spouse ❒ Child ❒ Other

Name of secondary insurance (if applicable): Subscriber's name: Group no.:

Patient's relationship to subscriber: ❒ Self ❒ Spouse ❒ Child ❒ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address) Relationship to patient: Home phone: ( ) Work phone: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Liberty Hearing Centers & Dr. John P. Weigand AUD PC., or insurance company to release any information required to process my claims.

Signature of Patient or Guardian Date / /

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MEDICARE ASSIGNMENT

Name of Beneficiary _____ Health Insurance Claim # _____

I request that payment of authorized Medicare Benefits be made either to me, or on my behalf to Liberty Hearing Centers & Dr. John P. Weigand AUD PC., for any services rendered to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Patient's Signature _____ Date _____ Physician's Signature _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment to Liberty Hearing Centers & Dr. John P. Weigand AUD PC., of the medical benefits otherwise payable to me. I understand that I am financially responsible for all charges not covered by the assignment.

Patient's Signature _____ Date _____

PPO and MANAGED CARE SUBSCRIBERS

I understand that I must notify the physician's office if I decide to join or change my managed care plan. The proper referral with co-pay (if required) must be provided on the day medical services are rendered. Referrals are not retroactive. I understand that if I fail to notify the physician's office of my disenrollment or changes in the status of any eligibility within the plan, then I will be responsible for any outstanding balance on my account due to that change. I have read and understand the above text.

Patient's Signature _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any physician or other person who has attended or examined me or my family members to furnish (insurance carrier name) information with respect to any illness or injury, medical history or consultation, prescription or treatments and copies of all medical records. A photocopy of this authorization shall be considered as valid as the original.

Patient's Signature _____ Date _____

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GENERAL CONSENT TO TREATMENT

I, knowing that I require Medical care or a course of treatment, consent to diagnostic treatment procedures by the Liberty Hearing Centers & Dr. John P. Weigand AUD PC., or assistants or person(s) they designate.

I am aware that the practice of medicine is not an exact science. No guarantees have been made to me about the benefits or results of procedures and treatments authorized above.

I authorize Liberty Hearing Centers & Dr. John P. Weigand AUD PC., to use or dispose of any tissues or specimens resulting from the procedure(s) authorized above if applicable.

I further consent to the use of patient information for training and education purposes by Liberty Hearing Centers & Dr. John P. Weigand AUD PC., and their physicians; at the same time, Liberty Hearing Centers & Dr. John P. Weigand AUD PC., are to protect my identity.

By signing this consent form, I hereby authorize the provider and its medical staff to use and disclose my personal health information, as necessary for the purposes of obtaining medical treatment, enabling the provider and its staff to obtain payment for such treatment and for the normal business operations of the provider.

I have read and understood this form and I understand that I may ask for further explanations at any time.

Patient's Name (Print)	Signature	Date

HEALTHCARE AGENT/GUARDIAN: If the patient cannot consent for him/herself, the signature of either the health care agent or legal guardian who is acting on behalf of the patient or the next of kin who is assenting to the treatment for the patient must be obtained.

Healthcare Agent/Guardian (Print)	Signature/Relationship	Date

WITNESS: (To be signed by a facility employee who is not the patient's health care provider.) I have witnessed the patient or other appropriate person voluntarily signs this form.

Witness's Name (Print)	Signature	Date

Indicate if applicable: [ ] Patient is unable to sign, and next-of-kin is unavailable [ ] Patient refused to sign

INTERPRETER/TRANSLATOR: To be signed by the interpreter/translator if the patient required such assistance. To the best of my knowledge, the patient understood what was interpreted/translated and voluntarily signed this form.

Interpreter/Translator's Name (Print)	Signature	Date

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HIPAA PRIVACY FORM
NOP ACKNOWLEDGEMENT

This form will be provided to you upon registration.

Name of Patient/Personal Representative:

_____

NOTICE OF PRIVACY

You are entitled to our Notice of Privacy Practices describing how your health information can be used and disclosed by Liberty Hearing Centers & Dr. John P Weigand AUD PC. (LHC), and how you can obtain access to and control this information.

By signing below, I acknowledge that I have received the Notice of Privacy Practices.

_____ _____

Signature of Patient / Personal Representative Date

_____

Description of Personal Representative's Authority

FOR LHC EMPLOYEE USE ONLY

❒ Patient would not acknowledge receipt of NPP. Documentation of good faith effort to obtain acknowledgement and reason not obtained:

INDIVIDUALS INVOLVED IN CARE

Please identify family members, relatives or close personal friends that we may share your health information with who are involved in your care or payment for that care. We may also notify a family member, personal representative or another person responsible for your care about your location and general condition, or about the unfortunate event of your death.

Name: _	Name: _
Address: _	Address: _
Phone #: _	Phone #: _
Relationship: _	Relationship: _

LIBERTY
HEARING CENTERS
DOCTORS OF AUDIOLOGY

You're Information, You're Rights, Our Responsibilities

This notice describes how medical information about you may be used and disclosed and also how you can get access to this information. **Please review it carefully**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Patient's Bill of Rights

1. The patient has the right to privacy, confidentiality, respect and dignity provided by competent personnel.
2. The patient has the right to have his/her cultural, psychosocial, spiritual and personal values, beliefs, and preferences respected.
3. The patient has the right, upon request, to receive adequate information about the person(s) responsible for the delivery of his/her care, treatment and services.
4. The patient will be given information about the following: the licensed independent practitioner(s) responsible for any of the procedure; the licensed independent practitioner or staff member primarily responsible for the sedation and anesthesia; others authorizing or performing procedures and treatment.
5. The patient has the right, upon request, to be given the name of his/her attending practitioners, the names of all other practitioners directly participating in his/her care, and the names and functions of other healthcare persons having direct contact with the patient.
6. The patient has the right, upon request; to be given the credentials of all healthcare professionals involved in his/her care.
7. The patient has the right to be involved in decisions about care, treatment and services provided.
8. The patient has the right to consideration of privacy concerning his/her medical care program. Case discussion, all consultation, examination, treatment and medical records are considered confidential and will be handled discreetly.
9. The patient has the right to confidential disclosures and records of his/her medical care except as otherwise provided by law or third party contractual arrangement.
10. The patient has the right to participate in decisions involving his/her health care except when such participation is contraindicated for medical reasons.
11. The patient has the right to know what office-based endoscopy rules and regulations apply to his/her conduct as a patient.
12. Patients and, when appropriate, their families will be informed about the outcomes of care, treatment and services that have been provided, including unanticipated outcomes.
13. The patient has the right to refuse informed consent. No further needs and preferences, compliance with state law and regulation, patient education, nor medical treatment will continue if the patient refuses informed consent.
14. The patient has the right to expect emergency procedures to be implemented without unnecessary delay.
15. The patient has the right to high quality care delivered in a safe, timely, efficient and cost-effective manner, and the right to be assured that the expected results can be reasonably anticipated.
16. The patient has the right to full information, in layman's terms, concerning diagnosis, evaluation, treatment and prognosis, including information about alternative treatments and possible complications. When it is not medically advisable to give the information to the patient, the information will be given on their behalf to the person designated by the patient or to a legally authorized person.
17. The patient has the right to give informed consent prior to participation in a medical care research program or donor program. If the patient is unable to give consent, a legally authorized person has the right to be advised when a practitioner is considering the patient as part of a program. The patient or responsible person has the right to refuse to continue in a program in which they have previously given informed consent.
18. The patient has the right to refuse care, treatment and services in accordance with law and regulation. A practitioner shall inform the patient of the medical consequences of the patient's refusal of the care, treatment and services.

Patient's Bill of Rights

19. The patient has the right to refuse participation in experimental research.
20. The patient has the right to medical and nursing services without discrimination based upon age, race, color, religion, sex, national origin, handicap, disability or source of payment.
21. The patient who does not speak English has the right to have access, where possible, to an interpreter.
22. The patient who has vision needs, such as blindness, will have all documents read to them in full detail in the presence of a witness.
23. The patient who has a speech and/or hearing problem has the right to have access, where possible, to a computer/voice box/Telecommunications Device for the Deaf system.
24. The patient with cognitive impairments will have a member of the family or a designee in his/her presence at all times to help with instruction for every step of his/her treatment and care.
25. The patient has the right to expect the practice to provide his/her or other designee, upon request, access to the information contained in his/her medical record, unless the attending practitioner for medical reasons specifically restricts access. In addition, the patient has the right to expect a reasonable and timely transfer of information from one practitioner to another when required.
26. The patient has the right to expect good management techniques to be implemented within the practice. These techniques shall make use of time for the patient and avoid personal discomfort of the patient.
27. The patient has the right to be transferred to an acute care facility if there are complications or an emergency occurs.
28. The patient has the right to examine and receive a detailed explanation of his/her bill for services regardless of the source of payment.
29. The patient has the right inquire about the cost of a procedure.
30. The patient has the right to expect that the practice will provide information for continuing healthcare requirements following discharge and the means for meeting them.
31. The patient has the right to change primary or specialty physician if another qualified physician is available.
32. The patient has the right to be provided with appropriate information regarding the absence of malpractice insurance coverage.
33. The patient has the right to be informed of his/her rights at the time of admission.
34. The patient has the right to review the credentials of the professionals providing his/her care.
35. The patient has the right to receive relief from pain.
36. The patient has the right to be advised of all reasonable options/alternatives for care and treatment and any or all the potential advantages/disadvantages of each. Included in this should be a discussion of the advantages/disadvantages and alternatives to having the procedure performed in the office.
37. The patient has the right to education to address his/her needs. The educational process should take into consideration the patient's values, abilities, readiness to learn and patient and family responsibilities in the care process.
38. The patient has the right to file a complaint about the practice or any of the practice employees.

Health History Intake Form

Today's Date:_____

Patient's Name:_____ **Date of Birth:** _____**Age:**_____

Previous Primary Care Physician (if any):_____

Phone:_____**Address:**_____

Other Physicians involved in your care:_____

Allergies (Medication/Food, indicate reaction): ☐ None

_____

_____

Medication List: (Please list name/dose/frequency if known)

_____ _____
_____ _____
_____ _____
_____ _____

Family History: (please indicate deceased or alive, medical issues and age)

Father:_____
Mother:_____
Siblings:_____

Habits:

Alcohol: ☐ None ☐ Yes: How many drinks/day_____frequency/week_____What kind_____
Tobacco: ☐ None ☐ Yes: Chew or smoke?_____How many/day_____since_____
Caffeine: ☐ None ☐ Yes: What kind_____How many/day _____
Other Recreational Drugs: ☐ None ☐ Yes: What kind_____How many/day _____
Do you drive? ☐ Yes ☐ No Do you always wear a seatbelt? ☐ Yes ☐ No
Do you exercise? ☐ Yes ☐ No If yes, how much?_____

Past Surgical History (indicate date if known)

☐ None
☐ Cataracts_____ ☐ Colonoscopy_____
☐ Tonsillectomy_____ ☐ Hernia_____
☐ Thyroidectomy_____ ☐ Spinal Surgery_____
☐ Adenoidectomy_____ ☐ Orthopedic/joints_____
☐ Coronary Bypass_____ ☐ Prostate surgery/resection_____
☐ Cardiac Stents_____ ☐ Bladder surgery_____
☐ Pacemaker_____ ☐ Chemotherapy_____
☐ Heart Valve_____ ☐ Hemorrhoidectomy_____
☐ Gall Bladder_____ ☐ Bowel/Stomach Resection_____

Past Medical History:

Head Aches	☐ Yes	☐ No	Date: _____
Stroke	☐ Yes	☐ No	_____
Seizures	☐ Yes	☐ No	_____
Pneumonia	☐ Yes	☐ No	_____
Diabetes (Type 1 or Type 2)	☐ Yes	☐ No	_____
Thyroid Disease (Low or High)	☐ Yes	☐ No	_____
Glaucoma	☐ Yes	☐ No	_____
Macular Degeneration	☐ Yes	☐ No	_____
Hearing Loss	☐ Yes	☐ No	_____
High Blood Pressure	☐ Yes	☐ No	_____
Blood Clots	☐ Yes	☐ No	_____
☐ Pulm Emboli (lung clots)	☐ Yes	☐ No	_____
☐ DVT (leg clots)	☐ Yes	☐ No	_____
Heart Burn, Reflux	☐ Yes	☐ No	_____
Stomach Ulcers	☐ Yes	☐ No	_____
Heart Disease	☐ Yes	☐ No	_____
☐ Coronary Disease	☐ Yes	☐ No	_____
☐ MI/heart attacks	☐ Yes	☐ No	_____
☐ Congestive Heart Failure	☐ Yes	☐ No	_____
☐ Atrial Fibrillation	☐ Yes	☐ No	_____
☐ Angina	☐ Yes	☐ No	_____
☐ Valve Disorder	☐ Yes	☐ No	_____
High Cholesterol	☐ Yes	☐ No	_____
Gastrointestinal Bleeding	☐ Yes	☐ No	_____
Hepatitis (A, B, C)	☐ Yes	☐ No	_____
HIV / AIDS	☐ Yes	☐ No	_____
Chronic Wounds	☐ Yes	☐ No	_____
Cancer (type)	☐ Yes	☐ No	_____
Urinary Tract Infections	☐ Yes	☐ No	_____
Incontinence	☐ Yes	☐ No	_____
Kidney Stones	☐ Yes	☐ No	_____
COPD (Emphysema, Bronchitis)	☐ Yes	☐ No	_____
Asthma	☐ Yes	☐ No	_____
Depression	☐ Yes	☐ No	_____
Bipolar Disorder	☐ Yes	☐ No	_____
Anxiety	☐ Yes	☐ No	_____
Fibromyalgia	☐ Yes	☐ No	_____
Chronic Fatigue Syndrome	☐ Yes	☐ No	_____
Arthritis	☐ Yes	☐ No	_____
Gout	☐ Yes	☐ No	_____
Osteoporosis	☐ Yes	☐ No	_____
Prostate Disease	☐ Yes	☐ No	_____
Breast Disease	☐ Yes	☐ No	_____
Erectile Dysfunction	☐ Yes	☐ No	_____
Other			

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HEARING CENTERS
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John Weigand, Audiology PC

445 Lenox Road, Suite J Room Al-435, Brooklyn, NY, 11203 Telephone (718)270-3976 Fax (718) 613-8557

Authorization/Consent to Provide Hearing Health Care & Bill Insurance

To Whom It May Concern:

Consent to Bill insurance

I, the undersigned, am hereby consenting to treatment as may be deemed necessary or advisable in the diagnosis and treatment of my Hearing Health care. I authorize the above named provider to submit claims to my insurance company. If it is the case that my insurance company utilizes a managed care company the provider agrees to discuss my treatment with a care manager and obtain any and all authorizations necessary for services. I give my authorization to use or disclose my protected health information (medical records) that may be required in order to administer any treatment deemed necessary in the diagnosis and treatment of my care. I realize that all charges incurred by me are my financial responsibility I authorize payment of medical benefits to the above named provider for all services he provides.

_____ _____

Patient Name Date

_____ _____

Patient Signature Date