



Hearing Consultants

Please read and acknowledge by signing below:

- I certify to the accuracy of the above information.
- I understand that I am personally responsible for the amount of charges regardless of insurance coverage and authorize the release of any medical or other information necessary to process claims.
- I understand my insurance benefit will be checked as a courtesy however I am responsible for understanding my insurance coverage.
- I further authorize payment of medical benefits directly to the undersigned provider.
- I hereby acknowledge that I received or have access to Hearing Consultants of Colorado Springs Notice of Privacy Practices. This is made available on our website, at our office or can be sent via mail.
- I understand that if I am unable to make my appointment I need to call and reschedule 24 hours prior to my appointment. I also understand if I arrive late for my appointment, I may be asked to reschedule or be worked into the day. **If I do not show for my appointment and do not call to office to cancel my appointment in advance, I will be considered a no show and will be charged a \$50 no show fee.**
- I understand if my check is returned for non-sufficient funds, I will be responsible for paying \$25 fee in addition to re-issuing payment for a returned check.
- Consent for Treatment:** I, the undersigned, voluntarily agree to the tests, procedures, and/or treatments which the provide as deemed necessary and which are administered to or performed on me under the direction of the provider or his/her designee.
- Consent of Treatment of Minors:** I, the undersigned, understand that a minor child (17 and under) must have my consent to be treated. I understand that I must be present at each appointment for any child aged 14 and under. If the child is between the ages of 15 and 17, I understand I must send a note with the child to the appointment for consenting treatment. The notes must contain the date, a statement of consent and my signature. Further I understand that consent for treatment does not alter the legal requirements for confidentiality. I also understand that Colorado Law Provides for minors to seek care without parental consent for certain issues.

Print name

Signature

Relationship to patient

Date

6375 Lehman Drive, Ste 100 • Colorado Springs, CO 80918

Phone (719) 633-1494 • Fax (719) 633-8129

www.myhearingconsultants.com



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Pediatric Case History:

Patient Name: _____

Date of birth: _____

Chief Complaint: _____

Are there concerns with hearing loss?

- Yes No

Hearing loss is in the:

- Right ear Left ear Both ears

Onset has been:

- Progressive Sudden Fluctuating

How long have you be concerned with hearing loss?

_____ Years _____ Months _____ Days

Is there a delay in speech or language development?

- Yes No

If yes, please explain:

Does the patient attend speech therapy?

- Yes No

Is there family history of hearing loss?

- Yes No

If yes, who has hearing loss?

Age of onset: _____

Is there a history of ear infections?

- Yes No

History of PE tubes?

- Yes No

When: _____

Please list or attach a list of current medications:

Was pregnancy full-term?

- Yes No

Did patient pass their newborn hearing screening?

- Yes No Unsure

Complications during birth? Check all that apply.

- Kidney concerns NICU stay
 Jaundice Blood transfusion
 Medications given Lack of oxygen

Other: _____

Medical conditions, please check all that apply.

- High fever Chemotherapy
 Seizure disorder ADHD/ADD
 Encephalitis Learning disability
 Vision loss Meningitis
 Asthma Other: _____

Has patient ever worn hearing aids?

- Yes No

Hearing aid in the:

- Right ear Left ear Both ears

What style was your hearing aid?

- Behind-the-ear In-the-Ear

Please explain your experience with hearing aids?

Known allergies:

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