Welcome to ClearSound Hearing Centers

Your appointment is on _____/_____/_____ @ _____:_____ AM / PM

Our team of dedicated Doctors of Audiology and Hearing Care Specialist are here to walk you through our treatment process, addressing your hearing loss and associated medical and cognitive needs.

Please know that during these trying times we are opened by appointment to continue to address your Hearing Wellness. Be advised that we are observing guidelines set by CDC. We schedule appointments so that there is a minimum number of people in office., everyones temperature is taken - non contact. Our staff wears gowns, masks, and gloves and everything is wiped down after each appointment. For you safety we also offer personal transportation via UBER to and from office for those that require it. The statistics are truly staggering! ***Nearly 50 million people in our country suffer from hearing loss, a progressive degenerative disorder***. Even more alarming is the fact that hearing loss can significantly increase your risk of developing Dementia. Fortunately, a recent report from the Lancet Medical Journal has found that ***early treatment of hearing loss is the most modifiable factor for preventing Dementia.***

Now that you know the magnitude of the situation, let me explain what to expect when you come in for your evaluation:

First, we want to get to know you and understand how your hearing loss is impacting you, your memory and your family. Honestly, it impacts everybody around you including the relationships you have with your family, friends, co-workers and community. **Second,** '*why*' we are, and '*who*' we are. We are proud of the practices that we have established in the Long Island, Queens, and Brooklyn communities, helping so many people. In our 20+ years of service, we have achieved a great reputation and countless accolades. We don't take these accomplishments lightly, striving every day with every patient to live up to your expectations – treating you with honesty, respect and empathy – the way it should be. **Third, we begin the process of *treating your hearing loss* by measuring your current deficits and developing a comprehensive plan to restore clarity and address your cognitive needs.** We discuss with you:

- Treatment options
- Symptoms you are experiencing (e.g. tinnitus, difficulty following conversation in background noise, issues with memory loss, lack of clarity, etc.,)
- How your hearing loss is impacting others around you
- The costs associated with treatment and how your insurance benefits could help
- The medical benefits of treating hearing loss including improvements in cognitive function, increase in quality of life, reduction of tinnitus and limiting your risk of developing cognitive decline, memory loss and Dementia.

Fourth, we begin treating your hearing loss immediately! Chances are, you have waited too long to begin treatment, and it is critical to begin now. Rest assured – we have made treatment affordable for all with many financing options! With our 100% satisfaction guarantee, you are making the right decision to treat your hearing loss at our practice.

To best treat your hearing loss and keep your brain healthy, we use the most advanced diagnostic procedures available. Dr Ed Aleo, Co-Founder of Clearsound Hearing Centers and author of *The Joy of Dispensing: Proven Methods to Help Patients Accept Hearing Aids*, in his private audiology practice working directly with patients, has created an Approved Testing Protocol used in practices throughout the country. This proven testing method identifies the extent of hearing loss and alows patients to ***hear their own hearing loss,*** which helps us develop the correct course of treatment to solve your specific issues.

Remember we accept most insurances. Including Emblem, HIP, GHI, Blue Cross / Blue Shield, United HealthCare, Aetna, Cigna, Union Voucher & Discount Plans, and Medicare.

Whatever your hearing needs are, our advanced treatment plans are customized to the cognitive aspects of your hearing loss.

THANK YOU for trusting us with your hearing healthcare. At ClearSound Hearing Centers - **Hearing Care is Health Care.**

Sincerely,

Dr. Raymond J. Catania

Dr. Alexandra Lewery

APPOINTMENT INFORMATION

LOCATION: _____

TIME: _____

DAY/DATE: _____

PHONE: (855) 423-3700
www.ClearSoundHearingNY.com

PATIENT REGISTRATION INFORMATION

Date: _____ Date of Birth:_____ Age: _____

Last Name:_____First Name:_____Middle Initial: Gender: ☐ Male ☐ Female

Address:_____Apt#:_____City:_____

State:_____Zip Code:_____Home Phone:_____Cell Phone: _____

Email:_____

Marital Status (circle one): Single/Married/Div./Sep./Widowed Spouse's Name (if applicable): _____

In case of emergency, who should we contact?_____Phone_____

Employer:_____Occupation:. Business Address:_____

_____Business Phone:_____

Primary Care Physician:_____Phone:_____

Address:_____

Referred by:_____Phone: _____

PRIMARY INSURANCE:

Person responsible for account:_____ Phone:_____

Relationship to Patient:_____ Date of Birth:_____

Address (if different from patient):_____

Ins. Company:_____Ins. Company Address:_____

Subscriber ID#:_____Group#:_____Co-pay:$_____

*Medical Insurance referral/Authorization Number (if available) _____

ADDITIONAL INSURANCE: (SECONDARY INSURANCE)

Person responsible for account:_____Phone:_____

Relationship to Patient:_____Date of Birth:_____

Address (if different from patient):_____

Insurance .Company:_____Insurance .Company Address:_____

Subscriber ID#:_____Group#:_____ Co-pay:$

*Medical Insurance Authorization Number (if available) _____

Signature: _____

HIPAA RELEASE OF INFORMATION AUTHORIZATION FORM

I hereby authorize ClearSound Hearing and its affiliates, its employees and agents to release to my personal health information maintained by my insurance carrier, Information LIMITED ONLY TO AUDIOLOGY CONCERNS. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. This authorization is valid from the date of my/my representative's signature below and shall expire the date my coverage ends with my insurance carrier. I understand that I have a right to revoke this authorization by providing written notice to Clearound Hearing However this authorization may not be revoked if ClearSound Hearing Its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

_____ Date_·___ /_____/_____

Signature of Patient

CONSENT FORM FOR TREATMENT

The undersigned, patient, parent/legal guardian of the above named patient does hereby empower and grant to Audiologists of ClearSound hearing my consent permission of any examination, medical diagnosis, tests, treatment, including dilation, to be rendered for myself or my child/ward.

_____ Date_·_ /_____/_____

Signature of patient/ parent/ legal guardian

CLAIMS SUBMISSION

- I hereby assign, transfer and set over to the above named physician group and facility sufficient monies and or benefits to which I may be entitled from government agencies, insurance carriers and/or other who are financially liable for the cost of care and treatment rendered to the patient.
- I authorize the above named physician group and facility to release any and all records, medical history, services rendered or treatment given to the patient for purpose of review, investigation or evaluation of any claim submitted to my insurer(s).
- I authorize the transferring of any and all necessary personal medical or demographic information required by the pharmacy in order to fill or refill medication prescriptions. I understand that this information may be transferred electronically, verbally or in writing.

I understand that some services may require approval of my primary care physician for coverage, and that if I do not obtain that approval, I am financially liable for the services.

I understand that some services and products may not be covered by my insurance carrier and that benefit information does not constitute approval of payment. Fees not paid by my insurance carrier will be my responsibility.

Patient Name: _____

Signature of Patient' or Guarantor _____

Date _____/_____/_____

AUDIOLOGY CASE HISTORY FORM

Name: _____ Date:_____

Presenting Problem

1. What is your primary complaint about your ears or hearing? _____
2. What do you think caused your hearing problem? _____
3. If you have a hearing loss, how long have you noticed this? _____
4. Which is your worse ear (if they are different): Left _____ Right _____
5. Do you have difficulty understanding:

   TV: Yes_____ No_____ Telephone: Yes_____ No_____ In groups: Yes _____No_____

6. How important is it for you to improve how you hear, understand, or communicate with others RIGHT NOW (mark on the line)

0 10
(Not at all important) (Extremely important)

History

1. Have you had your hearing tested before? Yes_____ No_____ If yes, when and where?:

_____

2. Any drainage from the ear within the past 90 days? Yes_____ No_____
3. Have you experienced any dizziness, balance problems, or falls? Yes_____ No_____
4. Have you had any pain/discomfort in your ears within the past 90 days: Yes_____ No_____

   If yes, rate your pain on a scale of 0 (no pain) to 10 (worst pain possible) _____

5. Have you ever lost hearing in one ear *suddenly*? Yes_____ No_____
6. Do you have any noises or ringing in your ears? Yes_____ No_____ left/right/both

   If present, is it: Constant _____Intermittent _____ When did you first notice it? _____

7. Have you received any medical or surgical treatment for hearing loss? Yes_____ No_____
8. Do you have trouble with arthritis, stiffness, numbness in your fingers? Yes_____ No_____

*****CONTINUE ON NEXT PAGE*****

9. Have you ever been exposed to loud noise? Military Occupation/Job Recreational

   If yes, describe the type of noise: _____

   Did you use ear plugs/muffs? Yes_____ No_____

10. Is there a history of hearing loss in your immediate family? Yes_____ No_____

    If yes, who: _____

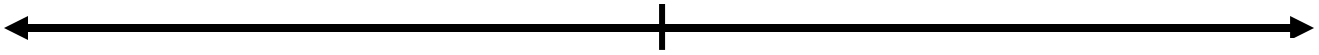
11. Medical problems (check all that apply):

    Infectious disease _____ Diabetes _____ Heart problems _____ Head injury _____
    High blood pressure _____ Headache _____ Kidney failure _____
    Pacemaker/Defibrillator _____
    Other (please explain): _____

12. Have you ever worn a hearing aid(s)? Yes _____ No _____

    If yes, how would you rate your experience with your hearing aid(s) on a scale of 0 (terrible) to 10 (great)? _____

13. How confident are you in your own ability to use and take care of hearing aids if they are recommended? (mark on the line)



0 10
(Not at all confident) (Extremely confident)

14. In what situations would you most like hearing aids to help you (if recommended)?:
    Conversations with family or friends _____ TV _____ Telephone _____ In the car _____
    Places of worship _____ Music _____ Other: _____

15. Select all that apply:
    _____ I am not ready for hearing aids at this time.
    _____ I have been thinking that I might need hearing aids.
    _____ I have started to seek information about hearing aids.
    _____ I am ready to wear hearing aids if they are recommended.
    _____ I am comfortable with the idea of wearing hearing aids.
    _____ I currently wear hearing aids.

Comments or questions for the audiologist:

_____
_____
_____
_____