



COLORADO SPRINGS

EAR ASSOCIATES

Name _____ Age _____ Date of Birth _____ Date _____

MEDICAL HISTORY: Please mark any medical problems you have been or are being treated for.

High Blood Pressure
Heart Disease
Heart Attack
Atrial Fibrillation
Pacemaker
Stroke/TIA

Heart stents/bypass
Blood clots/DVT
Parkinsons
Acid reflux/ulcers
Diabetes
Brain tumors

Joint Replacements
Arthritis
Thyroid problems
Use Oxygen
Asthma/COPD
Allergies/Sinusitis

Sleep apnea
Migraines
Anxiety
TMJ

How would you rate your overall health? Excellent Good Fair Poor

SURGICAL HISTORY: Please note all the ear surgeries & procedures you have had in the past.

Ear Tubes

Stapedectomy

Tympanoplasty

Mastoidectomy

OTOLOGIC HISTORY: Please mark if you have had exposure to any of these below (include year of exposure).

Unprotected noise exposure
Gentamycin

Ear injury
Vancomycin

Chemotherapy
Meningitis

Gun shooting
Ear infections

SOCIAL HISTORY:

What is your current occupation? _____

Do you smoke or vap? No Yes Use Marijuana? No Yes
Do you drink alcohol? No Yes _____ drinks/week
Do you use caffeine? No Yes _____ cups/day

Currently disabled? No Yes Reason for disability _____

ALLERGIES TO MEDICATIONS: Please list the reactions you have had to each medicine. If nothing is listed, no allergies known.

1.	3.
2.	4.

MEDICATIONS: Please list of all the medicines you take (include strength and how often they are taken).

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

FAMILY HISTORY: Mark if any blood relative has had any of the following conditions. Please indicate which relative.

Congenital deafness
Cochlear implant

Premature hearing loss
Migraines

Otosclerosis
Meniere's

Bleeding/Blood clots
Anesthesia reactions

HEARING & BALANCE QUESTIONNAIRE

I. DIZZINESS: Please describe in your own words the sensation you feel regarding your balance. Skip if you are not feeling dizziness.

Please mark all that apply:

Feels like:	lightheadness	spinning	motion-sickness	drunk	floating	head bobbling
Lasts for:	seconds	minutes	hours	days	weeks	constant
Worse when:	rolling in bed	head moving	looking up/down	walking	getting up	in the dark
I've been dizzy:	days	weeks	months	years	decades	
Better when:	not moving	physical therapy	meclizine			

II. HEARING LOSS: Please describe in your own words the problem you are having with your hearing. Skip if you do not have hearing loss.

Please mark all that apply:

Hearing loss present:	days	weeks	months	years	born with it
Most difficulty with:	women	men	telephone	crowds	restaurants
Hearing aids:	I don't have	they help	they don't help	they squeal	they hurt
Trauma history:	gun shooting	military noise	ear infections	ear tubes	ear surgery

III. EAR RINGING: Please describe in your own words the problem you are having with tinnitus. Skip if you do not have tinnitus (ringing).

Please mark all that apply:

Tinnitus present:	days	weeks	months	years	lifelong
Risk factors:	noise exposure	TMJ	neck problems	caffeine use	salt use
Location:	left ear	right ear	head	ear & head	can't tell
Sounds like:	air leaking	motor hum	crickets	ocean	clicking
	hissing	paper crinkling	heartbeat	static	crackling

Loudness scale: Right ear 0 _____ 10 Left ear 0 _____ 10
(0-barely hear it, 10-fire engine) ("X" the loudness level on the scale above)

SYSTEMS REVIEW

Please mark all conditions that apply to your **current** health.

GENERAL:

N Y
 Fevers
 Weight Loss
 Chills
 Night sweats

EYES:

N Y
 Macular Degen
 Double vision
 Retinoblastoma
 Detached retina

ENT:

N Y
 TMJ
 Allergies
 Loss of smell
 Nasal polyps

HEART:

N Y
 High blood pressure
 Palpitations
 Recent heart attack
 Passing out

LUNGS:

N Y
 Asthma
 COPD
 Cough
 On oxygen

HEME/LYMPH:

N Y
 HIV/AIDS
 Hemophilia
 Blood clots/DVT
 Easy bruising

MUSCULOSKELETAL:

N Y
 Neck surgery
 Back surgery
 Numb feet
 Fibromyalgia

SKIN:

N Y
 Psoriasis
 Face cancer
 Rashes
 Ear lesions

NEUROLOGICAL:

N Y
 Migraines
 Multiple sclerosis
 Stroke
 Parkinsons

GI:

N Y
 Vomiting
 Heartburn
 GERD
 Ulcers

GU:
N Y

STDs
 Incontinence
 Kidney stones
 Kidney failure

ALLERGY/IMMUNO:
N Y

Seasonal allergies
 Food allergies
 Slow wound healing
 Anaphylaxis

ENDOCRINE:
N Y

Hot/Cold Intolerance
 Use birth control
 Thyroid lump
 Recent hair loss

PSYCHIATRIC:
N Y

Mania
 Paranoia
 Insomnia
 Depression

Unless at **Y** box
 is filled, these Systems
 are Negative **N**

Patient Signature _____

Date _____

Physician Signature *Joseph Hegarty MD*



Joseph L. Hegarty, M.D.

Michael Iliff, Au.D.

Jessica Danforth, Au.D.

Roldan Alegre, DPT

Allison Thompson, P.A.-C

Cassie Iliff, Au.D.

Elyse Kady, Au.D.

Adult & Pediatric Ear Care - Hearing Aid & Cochlear Implant Center - Balance Disorders Center - Skull Base Surgery Center

PATIENT PROFILE

PERSONAL INFORMATION

First Name:	Last Name:	DOB:	Age:	
Phone Number:	Email Address:	SSN:		
Mailing Address:	City:	State/Zip:		

PROVIDER INFORMATION

Referring Provider:	Primary Care Physician:
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FINANCIAL INFORMATION

Current Balance:

Patient is financially responsible for their care: Yes_____ No_____ If No, please provide Guarantor information:

Name:	DOB:	Relationship:
Phone Number:	Email Address:	SSN:
Mailing Address:	City:	State/Zip:

FINANCIAL POLICIES

1. Private Insurance: You are responsible for deductibles, copays, coinsurance, any non-covered services including out-of-network charges specific to your plan, and items considered not medically necessary by your insurance company. Copays and deductible amounts are due at time of service. Balances are due 30 days after receipt of payment from your insurance company. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted.

2. Private Pay: Please make payment for your care at each patient visit.

3. Medicare: Our office will submit your Medicare charges to Medicare and your secondary insurance, if applicable. You are responsible for co-insurance, co-pays, and any non-covered services.

4. Balances Due: Invoices are emailed immediately after your claim has been processed. Payment is due within 30 days of the invoice email date. Reminder emails will be sent 30 and 60 days after the invoice email date. A 5% late fee will be added to all invoices that are 60 days overdue. Unpaid invoice balances will be transferred to a debt collection service 90 days after the initial invoice email date. We can no longer accept payment for balances after an account has been transferred to a debt collection service.

5. Paperless Billing: Our offices do not mail paper invoices; we email invoices when balances are due. Patients may also log in to the Invoice Portal on our web sites to view their invoices and statements. Patients who choose to opt out of paperless billing will be charged a processing fee for each paper invoice mailed to them.

GUARANTEE OF PAYMENT

1. I understand that I am responsible for payment of all fees and services rendered, irrespective of insurance coverage or other responsibilities. **NOTE:** We will bill your primary insurance. If insurance does not pay in a timely manner (within 90 days from the date of service and insurance filing), the insured will be expected to pay the balance and then pursue reimbursement from the insurance company. I understand there is a \$50 fee for any returned check for non-sufficient funds. **The guarantor of each account is ultimately responsible for payment in full of the account.**

2. I have been advised that if my commercial insurance carrier/HMO/Medicare plan claims that the services I receive from Colorado Springs Ear Associates are not considered reasonable and medically necessary for my care, I will be responsible for payment of these services.

3. I understand that my insurance plan may require my primary care physician to obtain an **authorization number** for the services that I receive from Dr. Hegarty. I have been advised that if I did not request a referral **and** authorization from my PCP in advance, my insurance plan may deny payment for services and I will be responsible for payment of all services.

4. I understand that it is my responsibility to determine if Joseph Hegarty, M.D. is a network physician for my **specific insurance plan** even if I have been advised that he is contracted with most commercial insurance companies. I understand that I may be responsible for paying out-of-network fees if relevant.

ASSIGNMENT

1. I assign the benefits from my insurance carriers to this office for the medical/surgical benefits to which I am entitled.

2. I request that payment of authorized Medicare benefits be made on my behalf to Colorado Springs Ear Associates for any service furnished to me by these providers.

RELEASE OF INFORMATION

1. I authorize Colorado Springs Ear Associates to release to my insurance carrier(s) any information needed to determine benefits payable for services.

2. I authorize Colorado Springs Ear Associates to release any information regarding my evaluation and treatment to my Referring/PC Providers.

3. I authorize any physician, hospital, laboratory or x-ray facility to release to Colorado Springs Ear Associates any and all medical information, hospital records, laboratory studies or x-rays that may be requested. A copy of this authorization is as binding as the original.

4. I certify that all of my contact information is correct for communication purposes. Any corrections needed have been made.

ACKNOWLEDGMENT OF RECEIPT OF FINANCIAL POLICIES

_____ (initial) **I have read and understand the Colorado Springs Ear Associates Financial Policies.**

I authorize Colorado Springs Ear Associates to discuss my private health information with the following persons:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Signature of Patient

Email Address

Today's Date

Signature of Patient's Representative

Relationship