RESET



# Cochlear™ Hearing Center
# Patient Registration Form

PLEASE COMPLETE ALL FIELDS UNLESS INDICATED OTHERWISE.

## 01 Patient Information

Name: _____

Preferred Name: _____

Address: _____

_____

☐ Adult ☐ Child Date of Birth: _____

Email: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Other Phone: _____

Primary Phone: ☐ Home ☐ Work ☐ Cell ☐ Other

Are we able to leave a message? ☐ Yes ☐ No

Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to say

Preferred Language: ☐ English ☐ Spanish

## 02 Consent for Communication

To provide important updates regarding your care at the Cochlear Hearing Center, including information about appointments, orders, and clinic closures, we can communicate with you using several methods. Please choose yes or no for **ALL** communication methods. You may change your preferences at any time by notifying the Cochlear Hearing Center.

### Communication Preferences

Mail: ☐ Yes ☐ No

Phone (Voice): ☐ Yes ☐ No

SMS (Text): ☐ Yes ☐ No

Email: ☐ Yes ☐ No

## 03 Emergency Contact

Name: _____

Relationship to Patient: _____

Phone: _____

## 04 Responsible Party

Enter information below if different than patient.

Name: _____

Relationship to Patient: _____

Contact info same as above? ☐ Yes ☐ No (enter below)

Phone: _____

Email: _____

Address: _____

_____

## 05 Primary Healthcare Providers

Primary Care Physician: _____

Primary Care Physician Phone: _____

Ear Nose and Throat (ENT) Physician: _____

ENT Phone: _____

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## 06 Confidential Communications Consent

It is the office policy of the Cochlear Hearing Center not to release confidential medical and health information regarding your treatment to family members or friends, except for 1) parent/legal guardian; 2) persons authorized by the patient; 3) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment); 4) in emergency situations, or 5) as otherwise permitted by the Health Insurance Portability and Accountability Act (HIPAA).

- If you give us permission to communicate your health information to someone else, you understand that this could include any information in your medical record including test results, diagnoses, procedures, etc.
- You have been provided with a copy of Cochlear's Notice of Privacy Practices and understand other ways Cochlear can use or disclose your health information not otherwise listed on this form.

You can change your decisions on this form at any time by completing a new form. We cannot change information on this form over the phone. If you want anything changed on this form, including canceling your authorization, please contact us to complete a new form. You will be asked to review or update this form at least annually on your next visit to our office. If you cancel this authorization, you understand that the doctor or Practice may have already released information about you after you gave permission.

Please list the name(s) of the person(s) below who you give us permission to communicate your health information and the kind of information you permit us to communicate:

### Person 1

Name : _____

Phone : _____

Relationship to patient : _____

Information that can be shared:

☐ Billing information

☐ Appointment information

☐ Medical information

### Person 2

Name : _____

Phone : _____

Relationship to patient : _____

Information that can be shared:

☐ Billing information

☐ Appointment information

☐ Medical information

### Person 3

Name : _____

Phone : _____

Relationship to patient : _____

Information that can be shared:

☐ Billing information

☐ Appointment information

☐ Medical information

By signing below, you allow us to communicate your health information to you and permit us to share your health information with other persons, as indicated above.

Patient/Guardian Signature: _____ Date: _____

Patient Name: _____

## 07 Primary Insurance

Insurance Company: _____

Insurance ID: _____

Group #/Name: _____

Insurance Phone: _____

Subscriber Name: _____

Relationship to Patient: _____

Subscriber Date of Birth: _____

Subscriber Employer: _____

Subscriber Employer Phone: _____

Subscriber Employer Address: _____

_____

## 08 Secondary Insurance

Insurance Company: _____

Insurance ID: _____

Group #/Name: _____

Insurance Phone: _____

Subscriber Name: _____

Relationship to Patient: _____

Subscriber Date of Birth: _____

Subscriber Employer: _____

Subscriber Employer Phone: _____

Subscriber Employer Address: _____

_____

## 09 Financial Responsibility

I am financially responsible for all charges, and guarantee payment of this account.

Payment and/or insurance bill-to information is required at time of service. There will be a $25.00 fee for all returned checks. For convenience purposes, we accept all major credit cards.

I am required to provide at least 24-hour advance notice of cancellation or I may be subject to a cancellation fee of $25.

I authorize the release of any medical and/or other information necessary to process my medical claim. I also authorize payment of government benefits or any other insurance benefits to the party who accepts assignment.

Further, I authorize payment of medical benefits to be made directly to the Cochlear Hearing Center or Cochlear Clinical Services for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

Additionally, I acknowledge that I am financially responsible for all charges, and if a medical claim is submitted but is denied in whole or in part, and is moved to Patient Responsibility by the Payor, I guarantee payment of this account.

Patient/Guardian Signature: _____ Date: _____

## 10 Consent to Treat

I consent to receive audiological services at the Cochlear Hearing Center. This consent encompasses audiological procedures including, but not limited to, diagnostic testing and rehabilitative treatment.

I understand that this consent form will be valid and remain in effect as long as I receive audiological care at the Cochlear Hearing Center.

Patient/Guardian Signature: _____ Date: _____

## 11 Acknowledgment of Notice of Privacy Practices and Electronic Disclosure Notice

The Cochlear Hearing Center has provided a copy for your review of the following two documents:
A) Notice of Privacy Practices
B) Electronic Disclosure Notice (Required under Texas Health and Safety Code §181.154)

Patient Name (printed): _____

Patient/Guardian Signature: _____ Date: _____

## 12 Release of Information

I understand that I/my child, _____, will be evaluated for hearing loss, hearing aids, or hearing implant technology at the Cochlear Hearing Center. I consent to allow the secure storage of test results obtained during appointments that I/my child attend at the Cochlear Hearing Center in an electronic database. I understand that such test results will primarily be used for clinical purposes. By signing below, I provide permission for routinely collected data to be stored in a secure clinical database.

Patient/Guardian Signature: _____ Date: _____

I also understand that some of the data related to my/my child's appointment may be suitable for use in a future research study. If my/my child's data is used for research purposes, I understand that I/my child will not be identified in any of the study findings since data will be stripped of any identifying information prior to analysis. By signing below, I provide permission for data collected routinely during my/my child's appointments to be used for research purposes.

Patient/Guardian Signature: _____ Date: _____

This permission will remain valid until it is revoked in writing by me, to the program listed below, when I indicate the permission is to be ended: Cochlear Hearing Center, 4710 Bellaire Blvd, Suite 325, Bellaire, TX 77401

# 13 Medical and Hearing History

Please check all that apply and/or enter details for your hearing and general health.

## Hearing History

History of hearing loss: ☐ Left ear ☐ Right ear

Gradual hearing loss: ☐ Left ear ☐ Right ear

Sudden hearing loss: ☐ Left ear ☐ Right ear

History of ear infections: ☐ Left ear ☐ Right ear

Noise exposure: ☐ Left ear ☐ Right ear

Tinnitus (ringing): ☐ Left ear ☐ Right ear

Previous ear surgery: ☐ Left ear ☐ Right ear

Please describe ear surgery:

**Age hearing loss was first identified**

Left ear: _____ Right ear: _____

**Most recent hearing test** ☐ N/A

Date: _____

Clinic Name: _____

Results (If you have a copy of your most recent hearing test, please send it with this form or bring to your appointment):

## General Health

How is your general health?

Current medications (include non-prescription drugs):

Recent hospitalizations, surgery or chemotherapy:

## Medical History and Diagnoses

☐ Allergies
☐ Arthritis: ☐ Rheumatoid
☐ Autoimmune disease
☐ Bell's Palsy
☐ Cancer, type/treatment: _____
☐ Dementia
☐ Depression/anxiety
☐ Diabetes: ☐ Type I ☐ Type II
☐ Dizziness/vertigo: _____
☐ Family history of hearing loss: _____
☐ Head trauma: _____
☐ Heart/vascular disease
☐ Hepatitis
☐ High blood pressure
☐ High cholesterol
☐ High fevers
☐ HIV
☐ Kidney disease
☐ Measles
☐ Meningitis
☐ Multiple Sclerosis
☐ Mumps
☐ Pacemaker
☐ Parkinson's
☐ Scarlet Fever
☐ Seizures
☐ Sleep apnea
☐ Stroke
☐ Tuberculosis
☐ Vision problems

Patient Name: _____

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## 14 Hearing Device History

Please check all that apply and enter details for your current hearing device, if applicable.

**Do you have a hearing aid?**

☐ Left ear Date fit: _____ Age first used: _____

☐ Right ear Date fit: _____ Age first used: _____

**Do you have a cochlear implant?**

☐ Left ear Date activated: _____

☐ Right ear Date activated: _____

**Do you have a Cochlear Baha or Osia Sound Processor?**

☐ Left ear Date activated: _____

☐ Right ear Date activated: _____

**Are you satisfied with your current device?**

☐ Yes

☐ No, why?

### Hearing satisfaction in everyday listening conditions

| | Very Satisfied | Satisfied | Neutral | Dissatisfied | Very Dissatisfied |
|---|---|---|---|---|---|
| Understanding what is on TV | ☐ | ☐ | ☐ | ☐ | ☐ |
| Talking with small groups (3–5 people) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hearing in background noise | ☐ | ☐ | ☐ | ☐ | ☐ |
| Listening to and appreciating music | ☐ | ☐ | ☐ | ☐ | ☐ |
| Talking on the telephone | ☐ | ☐ | ☐ | ☐ | ☐ |

## 15 Specific Concerns

Please describe specific concerns you would like to address.

Patient Name: _____

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## 16 Digital Basic Skills Assessment Questions[1]

Please check all that apply.

| Digital Basic Skills Category | Action | I have no idea what you're talking about | Could you do this? I **could** do this if I was asked to | Could you do this? I **couldn't** do this if I was asked to | Have you done this in the last 3 months? I **have** done this in the last 3 months | Have you done this in the last 3 months? I **haven't** done this in the last 3 months |
|---|---|---|---|---|---|---|
| **Managing Information** | Use a search engine to look for information online | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Download/save a photo you found online | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Find a website you have visited before | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Communicating** | Send a personal message to another person via email or online messaging service | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Carefully make comments and share information online | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Transacting** | Buy items or services from a website | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Buy and install apps on a device | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Problem Solving** | Solve a problem you have with a device or digital service using online help | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Verify sources of information you found online | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Creating** | Complete online application forms which include personal details* | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Create something new from existing online images, music or video | ☐ | ☐ | ☐ | ☐ | ☐ |

## 17 Submit Form

For your convenience, you can email, fax or mail your completed registration form to us.

☐ **Cochlear Hearing Center San Antonio**
5282 Medical Dr, Suite 105
San Antonio, TX 78229
Telephone: 210 474 6766
Fax: 830 205 9186
Email: chcinfo-sa@cochlear.com

☐ **Cochlear Hearing Center Houston**
4710 Bellaire Blvd, Suite 325
Bellaire, TX 77401
Telephone: 800 216 9178
Fax: 800 216 9134
Email: chcinfo-hou@cochlear.com

**Policy:**

1. Watling S. Building a digital capabilities framework Part 1 [Internet]. digital academic. 2016 [cited 2023 Apr 20]. Available from: https://digitalacademicblog.wordpress.com/2016/01/04/building-a-digital-capabilities-framework/.

You should talk to your physician about who is a candidate for cochlear implantation, the associated risks and benefits, and CDC recommendations for vaccination.

Please seek advice from your health professional about treatments for hearing loss. Outcomes may vary, and your health professional will advise you about the factors which could affect your outcome. Always read the instructions for use. Not all products are available in all countries. Please contact your local Cochlear representative for product information.



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Patient Name: _____

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