

**PRESBYTERIAN EAR INSTITUTE**

415 CEDAR ST SE  
ALBUQUERQUE, NM 87106  
(505) 224-7020 OFFICE

**Patient Registration (Please Print Clearly)**

TODAY'S DATE \_\_\_\_\_

Patient Name \_\_\_\_\_ Birth date \_\_\_\_\_  
Last Name First Name Middle Initial  
 Mailing Address: \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
 City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Physical Address (if different) \_\_\_\_\_  
 Sex ☐ Male ☐ Female SS# \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ ☐ Married ☐ Single ☐ Widowed ☐ Divorced  
 Ethnicity (**Select all that apply**) ☐ Hispanic ☐ Black ☐ White ☐ Native American ☐ Asian ☐ Other  
 Email: \_\_\_\_\_ Alternate Phone ( ) \_\_\_\_\_  
 Employer \_\_\_\_\_ Employer Phone ( ) \_\_\_\_\_  
 Who referred you? \_\_\_\_\_ Primary Care Physician \_\_\_\_\_  
 In case of emergency who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_  
 Person Responsible for Account \_\_\_\_\_

**Parent/Guardian/Personal Representative Information (Please Print)**

Name (Parent 1) \_\_\_\_\_ DOB: \_\_\_\_\_ Name (Parent 2) \_\_\_\_\_ DOB: \_\_\_\_\_  
 Relation to Patient \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
 Address if different from above \_\_\_\_\_ Email \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_ Occupation \_\_\_\_\_

**Primary Insurance (Please Print Clearly)**

Insurance Company Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
 Member ID# \_\_\_\_\_ Group # \_\_\_\_\_  
 Insured's Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_/\_\_\_\_/\_\_\_\_

**Secondary Insurance Is Patient covered by Additional Insurance? ☐ Yes ☐ No**

Insurance Company Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
 Member ID# \_\_\_\_\_ Group # \_\_\_\_\_  
 Insured's Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

**Signature**, I consent to treatment and have supplied all information to the best of my knowledge.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian, or Personal Representative

\_\_\_\_\_  
Date

☐ No Changes Signature: \_\_\_\_\_  
☐ No Changes Signature: \_\_\_\_\_  
☐ No Changes Signature: \_\_\_\_\_

Date: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Date: \_\_\_\_\_



**MEDICAL RECORDS RELEASE / REQUEST FORM**

**THIS FORM ALLOWS PRESBYTERIAN EAR INSTITUTE TO SEND MEDICAL RECORDS TO THE REFERRING DOCTOR, AUDIOLOGIST, AS WELL AS OTHER PROFESSIONALS AS INDICATED BELOW.**

**PATIENT INFORMATION**

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**INFORMATION TO BE RELEASED**

*\* PLEASE INDICATE SPECIFIC RECORDS TO BE RELEASED.*

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**PARTY RELEASING INFORMATION**

FACILITY NAME: \_\_\_\_\_

FAX NUMBER: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

**AUTHORIZATION**

BY SIGNING BELOW, I HEREBY AUTHORIZE THE ABOVE FACILITY TO OBTAIN PERTINENT INFORMATION, INCLUDING MEDICAL, SOCIAL AND EDUCATIONAL AS NEEDED. IN ADDITION, I AUTHORIZE THAT A PHOTO COPY OF THIS AUTHORIZATION BE ACCEPTED WITH THE SAME AUTHENTICITY AS THIS ORIGINAL. ANY PERSON OR AGENCY RECEIVING THIS INFORMATION IS DIRECTED TO TREAT IT AS CONFIDENTIAL. THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME. THE DISCLOSED INFORMATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT. THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE IT WAS SIGNED.

\_\_\_\_\_  
SIGNATURE OF PATIENT, GUARDIAN, OR PERSONAL  
REPRESENTATIVE

\_\_\_\_\_  
DATE

☐ No Changes Signature: \_\_\_\_\_

Date: \_\_\_\_\_

☐ No Changes Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## HIPAA PRIVACY POLICY

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY THE STUDENT HEALTH CENTER AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**Please note: Our full HIPAA Privacy Policy is available at the front desk of our office and we can also provide our full HIPAA policy handout for your records upon your request. You can also access the full form on our website at [peiabq.org/contact](http://peiabq.org/contact).**

### ACKNOWLEDGEMENT OF RECEIPT:

Federal law requires that we seek your acknowledgment of receipt of this Notice of Privacy Practices. Please sign below.

I acknowledge that I have received this Notice of Privacy Practices with an effective date of July 31, 2008, and that I understand that if I have any questions regarding this Notice, I may contact the Privacy Officer.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Signature of Parent/Guardian(specify which):

\_\_\_\_\_ Date: \_\_\_\_\_

### For Office Use Only

Signed Acknowledgment of Receipt received on \_\_\_\_\_.  
Initials \_\_\_\_\_

Notice of Privacy Practices sent/delivered on \_\_\_\_\_.  
Initials \_\_\_\_\_

Patient Refused or Failed to Acknowledge Receipt on \_\_\_\_\_.  
Initials \_\_\_\_\_



**CONSENT TO EMAIL OR TEXT USAGE FOR APPOINTMENT REMINDERS AND  
OTHER HEALTHCARE COMMUNICATIONS**

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information to the following Cell Phone number:

Cell Phone Number	(       )	—			
I authorize to receive email/text messages for appointment reminders and general health reminders/feedback/information in the Patient Portal to the following Email Address:					
The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).					
Signature		Name (please print)		Date	





PRESBYTERIAN EAR INSTITUTE  
415 CEDAR ST SE  
ALBUQUERQUE, NM 87106

Welcome to PEI. Our goal is to provide you with quality medical care in a friendly, safe and caring environment. Although we take pride in the quality of our services, we know there is always room for improvement. If you have any suggestions or concerns related to your care of the service you receive, please request to speak with our office manager. PEI is committed to maintaining the very highest standards of ethics and integrity. We are committed to ensuring that all affairs are conducted in accordance with all applicable laws, rules, regulations policies and procedures.

#### FINANCIAL AGREEMENT

I, the undersigned patient/guardian/parent, assign directly to Presbyterian Ear Institute all benefits otherwise payable to me for services rendered. I also authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronic. I acknowledge that co-pays and deductibles are due at the time of treatment. I accept full financial responsibility for all charges not covered by insurance.

#### APPOINTMENT NON-COMPLIANCE CONTRACT

PEI understands that not showing and late cancellations for appointments sometimes cannot be helped. As soon as you are aware that you will be unable to keep your appointment, please notify the office immediately. Patients who no show or cancel with less than 24 hours notice of their scheduled appointment will be charged a \$25.00 fee for which the patient, not the insurance company, is responsible. This fee must be paid in full before PEI will allow another appointment to be scheduled.

#### FACILITY AGREEMENT

Presbyterian ear institute (PEI) will make every attempt to make the wait comfortable, but we do insist that clients who are coming to Presbyterian Ear Institute for audiology testing (hearing tests), speech and language evaluation or therapy visits remain in the lobby while waiting for their provider. The provider will come to the lobby to accompany their client(s) to their office. **Guardians of minor clients must remain on Presbyterian Ear Institute property while the patient is being seen. No exceptions will be made.**

**All patients/visitors to PEI must sign in at the front desk prior to any appointments.**

Presbyterian ear institute (PEI) has several programs including a *parent infant program*, *speech and language therapy program*, and *Presbyterian Ear Institute Oral School*. The school has a playground on site, as well as classrooms and a learning center. Due to insurance liability these areas are for enrolled students of Presbyterian Ear Institute and their families upon staff supervision only.

*By signing below it is understood that all the above policies of Presbyterian Ear Institute will be followed.*

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PATIENT OR GUARDIAN (IF PATIENT IS MINOR)

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DATE

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PEI RECEPTIONIST

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DATE





PRESBYTERIAN EAR INSTITUTE

415 CEDAR ST SE  
ALBUQUERQUE, NM 87106

**AUDIOLOGY**  
**Adult Case History**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**GENERAL**

1. What is the primary reason for your appointment today?

\_\_\_\_\_  
\_\_\_\_\_

2. Who referred you to Presbyterian Ear Institute?

\_\_\_\_\_

3. Have you ever had a hearing test?

☐ Yes ☐ No

Where? \_\_\_\_\_

What were the results? \_\_\_\_\_

4. Do you have any concerns about your hearing?

☐ Yes ☐ No

5. In which ear do you hear the best?

☐ Right ☐ Left ☐ Same in both ears

6. Does anyone in your family have a hearing loss?

If so who? \_\_\_\_\_

☐ Yes ☐ No

7. Have you ever been exposed to occupational or recreational noise?

☐ Yes ☐ No

(Ex: military, music, gun fire)

If yes, please describe: \_\_\_\_\_

**MEDICAL**

8. Have you had earaches or drainage from your ears within the last 90 days?

☐ Yes ☐ No

9. Have you had medical/surgical treatment for your ears?

☐ Yes ☐ No

If yes, at what age? \_\_\_\_\_

10. Do you ever have dizziness, balance problems, or falls?

☐ Yes ☐ No

11. Do you experience any tinnitus (for example: ringing, buzzing, or roaring) in your ears?

☐ Yes ☐ No

If so, which ear? ☐ Right ☐ Left

How frequent? \_\_\_\_\_

Is it bothersome? ☐ Yes ☐ No

12. Do you have any concerns about your physical or mental development?

☐ Yes ☐ No

13. What is your general health?

☐ Good ☐ Average ☐ Poor

14. Please list any medications (including non-prescriptions) you are currently taking or have taken recently:

\_\_\_\_\_  
\_\_\_\_\_



15. Have you ever had any of the following?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Arthritis                   | <input type="checkbox"/> Diabetes Type II    | <input type="checkbox"/> Pacemaker       |
| <input type="checkbox"/> Allergies                   | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Parkinson's     |
| <input type="checkbox"/> Bell's Palsy                | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever   |
| <input type="checkbox"/> Cancer                      | <input type="checkbox"/> High Fevers         | <input type="checkbox"/> Seizures        |
| (Type/Treatment: _____)                              | <input type="checkbox"/> HIV                 | <input type="checkbox"/> Stroke/TIA      |
| <input type="checkbox"/> Concussion / Skull Fracture | <input type="checkbox"/> Measles             | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Dementia / Alzheimer's      | <input type="checkbox"/> Meningitis          | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Depression / Anxiety        | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Other: _____    |
| <input type="checkbox"/> Diabetes Type 1             | <input type="checkbox"/> Mumps               |  |

## HEARING HISTORY

16. Do you have difficulty hearing/understanding in any of the following activities?

- |                                      |                                      |  |
|--------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Watching TV | <input type="checkbox"/> Restaurants | <input type="checkbox"/> Meetings        |
| <input type="checkbox"/> Telephone   | <input type="checkbox"/> Movies      | <input type="checkbox"/> Worship Service |

17. Do you have trouble hearing a:

- |  |                                   |                                      |
|--|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Telephone ring      | <input type="checkbox"/> Doorbell | <input type="checkbox"/> Alarm Clock |
| <input type="checkbox"/> Fire/smoke detector | <input type="checkbox"/> Siren    | <input type="checkbox"/> Baby Cry    |

18. Have you ever worn a hearing aid?

☐ Yes ☐ No

19. Do you use a hearing aid now?

☐ Yes ☐ No

If yes, how long have you had a hearing aid? \_\_\_\_\_

- |  |                                |                               |
|--|--------------------------------|-------------------------------|
| On which ear do you use the hearing aid? | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| Do you wear it regularly?                | <input type="checkbox"/> Yes   | <input type="checkbox"/> No   |
| Do you feel you benefit from it?         | <input type="checkbox"/> Yes   | <input type="checkbox"/> No   |



Dear Families and Friends of PEI,

During this challenging time of the COVID-19 outbreak, Presbyterian Ear Institute is making some temporary changes to keep our patients, staff and community safer. We are closely monitoring the situation and following guidance from our public health officials and government agencies. Please read on to learn what to do prior to coming to PEI for your appointment.

The coronavirus spreads very easily. Therefore, before you come in, please contact us to reschedule your appointment if you:

- Have a cough and fever of 100.4 or higher.
- Are experiencing shortness of breath.
- Have traveled outside the state within the past two weeks.
- Have had contact with someone that has been diagnosed with COVID-19.

I understand that you may feel concern or have some uncertainty about attending your appointment. To help ease some of those feelings, I want to share with you the measures we are taking for everyone's safety.

For scheduled appointments:

- **Number of attendees:** Please limit the number of persons attending the appointment to no more than two adults and one child.
- **Screening:** We will screen temperature for all persons entering the building. Anyone with a temperature reading of 99.5 will be turned away.
- **Masking:** Everyone entering our building with need to wear a face covering. If you do not bring one, we will provide one. We will also have hand sanitizer and gloves available in the entranceway.
- **Comprehensive Cleaning:** Our staff is doing extra sanitizing of all surfaces, especially the work spaces, exam rooms, bathrooms and waiting area. Our providers will be sanitizing their areas between patients.
- **Social Distancing:** Seating in our waiting room will be marked at a distance of at least 6 feet from other seats. In hallways, we have implemented a one-way traffic flow with arrows to guide our staff and patients.

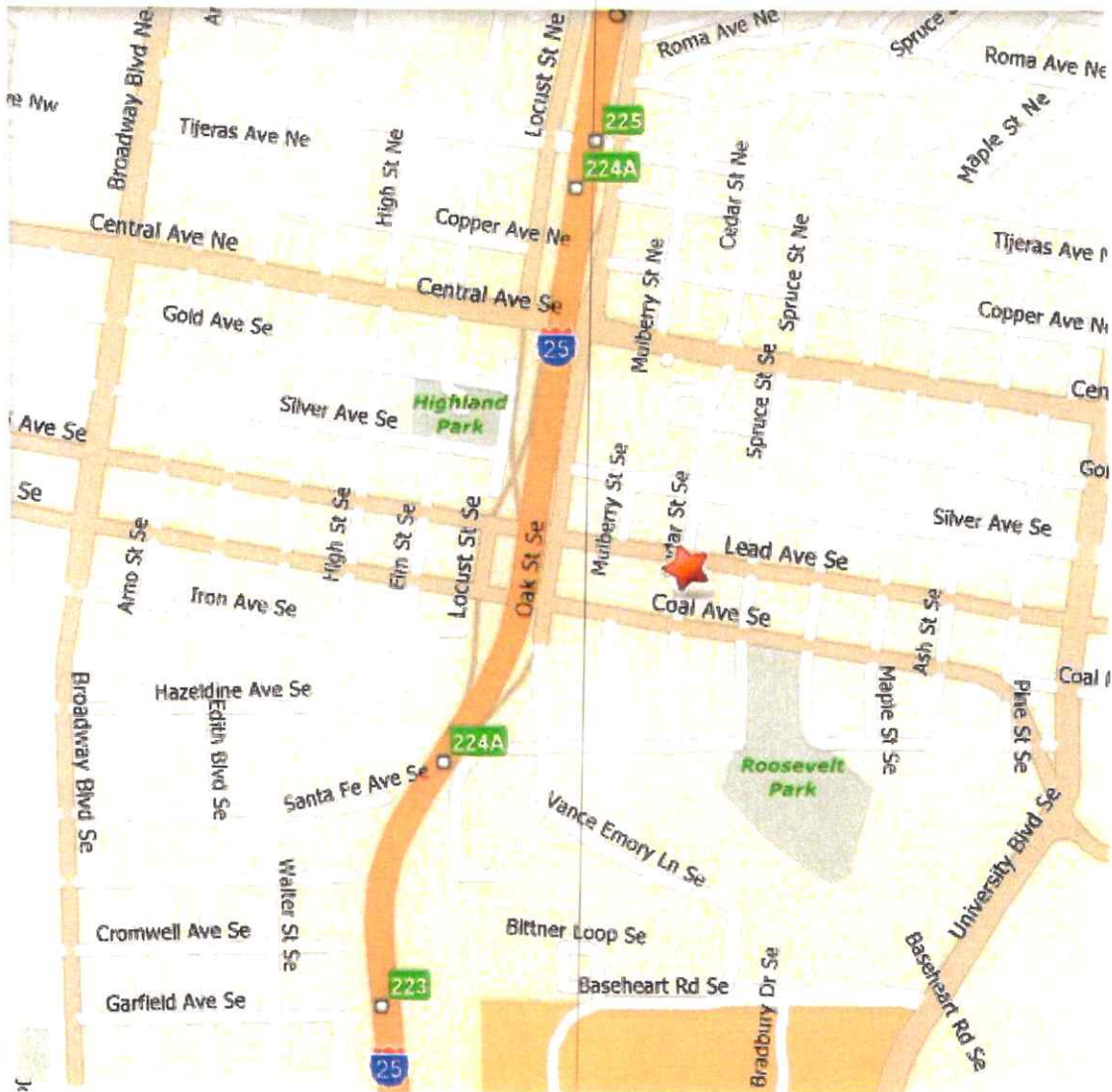
If you have any questions, concerns or need further clarification, please do not hesitate to call us at (505) 224-7020.

Warmest regards,

Dr. Seema LaGree, AuD  
Executive Director  
Presbyterian Ear Institute



### Map and Directions:



### Driving directions to Presbyterian Ear Institute from I-25 South

- Exit on the LEAD/COAL- exit 224A
- Head east on Coal
- Turn left on Cedar St.
- We are on the 1<sup>st</sup> floor at 415 Cedar St.