CLARK HEARING, INC

NEW CLIENT REGISTRATION FORM

(Please Print Clearly)

Today's date:

PERSONAL INFORMATION

Last name:	First name:	Middle Initial:	Marital status (circle one) Single / Mar / Div / Sep / Wid

Preferred Name:	Birth date: / /	Age:	Sex: ❑ M ❑ F	Occupation:

Mailing address:	Home phone: ( )	Cell phone: ( )

City:	State:	ZIP Code:	Email Address:

How did you hear about us? ❑ Dr. _____ ❑ Internet ❑ Mailer ❑ Insurance

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Newspaper ❑ other _____

Other family members seen here:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to client:	Home phone: ( )	Cell phone: ( )

PRIMARY CARE DOCTOR

Name of Doctor:	Location City:	Office phone: ( )	Fax line: ( )

I AM HERE TODAY BECAUSE ……

ABOUT YOUR HEARING AND HEALTH

Have you ever had a hearing test? Y / N if "yes" Date of last test _____

Do you currently wear hearing aids? Y / N

If "Yes" : Make _____ Model _____ Year _____

Which ear is aided: Right / Left / Both

When did you receive your first set of hearing aids? (Year) _____

Do you have pain or discomfort in your ears? Y / N **if "yes" Which ear?** Right / Left / Both

Sudden or rapid hearing loss in the past 90 days? Y / N

Sudden or long-term dizziness? Y / N ***(if "yes" explain)***:_____

Drainage in the last 90 days? Y / N

Do you have a history of ear infections? Y / N

Do you have Tinnitus *("Ringing")* in your ear? Y / N **if "yes" Which ear?** Right / Left / Both

Have you ever had any surgery on your ears? Y / N ***(if "yes" explain)***:_____

Do you have a Pacemaker? Y / N

Are you currently taking any Blood Thinners? Y / N

Are you currently being treated for any major medical conditions? Y / N

If "yes" please explain:

_____

INFORMED CONSENT AGREEMENT

I, _____ the undersigned, understand that the evaluation of the hearing system requires the use of specialized instrumentation.

During the course of the evaluation, I understand that the Hearing Care Professionals (HCP's) at Clark Hearing will be looking in my ear canals with various visual instruments and will thus have to physically touch my ears, head, shoulders, etc. Various earphones or earphone inserts (inserted into each ear canal) will be placed over my ears or in my ear canals. Acoustic (sound) signals will be delivered to the ears through either of these types of earphones. Some of the sounds will be loud, but scientific evidence has shown that these loud sounds will not cause any damage to the ear or to the hearing.

In the case of fitting for amplification (hearing aids), I consent to the placement of foam or cotton blocks into each external ear canal; as well as the placement of molding material (silicon) to make ear impressions if needed.

If it is determined that I have excessive earwax (cerumen), I consent to having cotton swabs and other ear cleaning instruments used to clean my ears. Additionally, water and hydrogen peroxide may be placed into my ear canals through a small irrigator tube to flush (lavage), clean and remove earwax from my ear canals. A lavage may only be performed on ears that have never undergone surgery, such as: the placement of a tube (myringotomy) through my eardrum (tympanic membrane); reconstruction of my eardrum (tympanoplasty), or my eardrum has been perforated. I understand that the HCP's at Clark Hearing, INC are not medical doctors, and that I must inform them of any ear surgeries, perforations, or other complications that I've had. I also understand that if I have excessive earwax, or other issues with my ears, which is beyond the scope of practice of Clark Hearing, INC that a medical referral will be necessary.

During the course of any these procedures a low percentage of patients will have slight bleeding and/or discomfort in their ears, which mainly occurs when the patient moves or twitches their head or body inadvertently. I understand that while the HCP's at Clark Hearing, INC are providing any of the services listed above, I need to remain as still as possible in order to help avoid any adverse effects.

By signing this Informed Consent Agreement, I hereby acknowledge that I understand the various procedures and risks described above, and that it is most often the patient's fault when an adverse incident arises. Therefore, if an adverse event were to occur, I will not hold Clark Hearing, INC or any Staff Member responsible for such an adverse event in the course of my hearing healthcare treatment by them unless it is deemed to be absolute negligence.

X_____ _____
Signature Date

If not signed by patient, please indicate relationship:

____ Guardian or Conservator of an incompetent patient
____ Personal representative of patient

For Office Use Only ____ Signed form received by: _____

Name of patient: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Our Privacy Pledge and Duties. While we have and always will respect your privacy, a new federal law now requires us to maintain the privacy of hearing health information and other medical information (including examination, treatment and billing records) about you and to provide you with this Notice of our legal duties and privacy practices with respect to such health information. We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change terms of our privacy notices. If we change the terms of the Notice, we will notify you during your next visit or by mail.

II. Permissible Uses and Disclosures Without Authorization. In certain situations, (described in Section III below), we must obtain your written authorization in order to use and/or disclose your health information. However, here are some examples of how we might use or disclose your health information (other than highly confidential information) without first obtaining your written authorization:

A. Uses and Disclosures for Treatment, Payment or Health Care Operations. 1. Treatment. Your hearing health care professional or staff member may use and disclose your health information to diagnose, assess and treat your health condition. 2. Payment. Our insurance and billing staff may disclose your health information to an insurance carrier, HMO, PPO, your employer, or other party that arranges or pays the cost of some or all of your health care, or to verify that such parties will pay for your health care. 3. Health Care Operations. Your hearing health care professional and members of the staff may use or disclose your health information for quality control purposes or for other administrative purposes to efficiently and effectively run his/her practice. 4. Appointment Reminders. Your hearing health care professional and members of the staff may need to use your name, address, phone number, and other health information to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine or at another location that you reasonably request. 5. Other Providers. Your hearing health care professional and members of the staff may use or disclose your health information to another health care provider, product manufacturer, or a hospital if it is necessary to refer you to them or they are otherwise involved in your care when such information is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance. B. Disclosures to Relatives, Close Friends and Other Caregivers. Your hearing health care professional and members of the staff may use or disclose your health information to one of your family members, other relative or a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure. If you object to such uses or disclosures, please notify your hearing health care professional. If you are not present, you are incapacitated or in an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. We may also disclose your health information to notify such persons of your location or general condition. C. Other Permitted Uses and Disclosures Without Your Authorization. Under federal law, we are also permitted or required to use or disclose your health information without your authorization in these following circumstances: 1. Public Health Activities. We may disclose your health information for certain public health activities such as (i) reporting health information to public health authorities for the purpose of preventing or controlling disease, injury or disability: (ii) reporting child abuse and neglect to authorities authorized by law to receive such reports; (iii) reporting information about products or services under the jurisdiction of the U.S. Food & Drug Administration; (iv) alerting a person who may have been exposed to a communicable disease or who may otherwise be at risk of contracting or spreading a disease or condition; and (v) reporting information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance. 2. Victim of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose health information to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect or domestic violence. 3. Health Oversight Activities. We may disclose your health information to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health care programs such as Medicare or Medicaid. 4. Judicial and Administrative Proceedings. We may disclose your health information

in the course of a judicial or administrative proceeding in response to a legal order or other lawful process. 5. Law Enforcement Officials. We may disclose your health information to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena. 6. Decedents. We may disclose your health information to a coroner or medical examiner as authorized by law. 7. Organ and Tissue Procurement. We may disclose your health information to organizations that facilitate organ, eye or tissue procurement, banking or transplantation. 8. Research. We may use or disclose your health information if an Institutional Review Board approves a waiver of authorization for use or disclosure. 9. Health or Safety. We may use or disclose your health information to prevent or lessen a serious and imminent threat to a person's or the public's health or safety. 10. Specialized Government Functions. We may use or disclose your health information to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances required by law. 11. Workers' Compensation. We may disclose your health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs. 12. As Required by Law. We may use or disclose your health information when required to do so by any other law not already referred to in the preceding categories.

III. Uses and Disclosures Requiring Your Authorization. A. Uses or Disclosure with Your Authorization. Other than the circumstances described above, any other use or disclosure of your health information will only be made with your written authorization. Additionally, you have the right to refuse to give us authorization to use or disclose your health information for purposes other than those described above. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. B. Your Right to Revoke Your Authorization. You may revoke your authorization to us at any time; however; your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request: 1. If we have taken an action in reliance upon such authorization before we receive your request to revoke your authorization. 2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke authorization, please write to us at the address given in Section VII below. C. Marketing. We must also obtain your written authorization prior to using your health information to make you aware of products or services that you may have an interest in purchasing from time to time. We can, however, provide you with marketing materials in a face-to-face encounter without obtaining your authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without first obtaining your authorization. Additionally, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings. D. Uses and Disclosures of Your Highly Confidential Information. In addition, federal and state law requires special privacy protections for certain highly confidential information about you. In order for us to disclose your highly confidential information for a purpose other than permitted by law, we must obtain your written authorization. E. Right to Refuse Authorization. You have the right to refuse to give us an authorization to use or disclose your health information or otherwise contact you for purposes other than those set forth in Section II above.

If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

IV. Your Individual Rights. A. Your Right to Receive Confidential Communication Regarding Your Health Information. We normally provide information about your health in person, at the time you receive hearing care services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide by an alternative means of communication or at an alternative location. To help us respond to your needs, please make any request in writing. B. Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of your health information (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your general location and general condition. All requests for such restrictions must be made in writing. While we consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. C. Your Right to Inspect and Copy Your Health Information. You may request access to your health information maintained by us in order to inspect and/or copy your health information. We require your request to inspect and/or copy your health information to be in writing. If you request copies, we will charge you $5.00 per page copied. We will

also charge you for our postage costs, if you request that we mail the copies to you. D. Your Right to Amend Your Health Information. You have the right to request that we amend your health information maintained by us. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make. E. Your Right to Receive an Accounting of the Disclosures We Have Made of Your Records. You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request, provided such request does not apply to disclosures that occurred prior to April 14, 2003. The accounting will include all disclosures except those disclosures: required to carry out treatment, payment and health care operations to you that are incident to a permitted use or disclosure made pursuant to an authorization. required to maintain a directory of the individuals in our facility or to individuals involved with your care required for national security or intelligence purposes to correctional institutions or law enforcement officers made as part of a limited data set made prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, we will charge $5.00 per page of the accounting statement.

V. Re-Disclosure. Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by federal law.

VI. Your Right to Obtain Further Information; Complaints. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about providing you access to your health information, please contact us. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, we will provide you with the address for the Director. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint or request information at any time, written comments should be addressed to:

Clark Hearing, INC
33300 Egypt Lane Ste G200
Magnolia, TX 77354

VIII. Your Right to Receive a Paper Copy of This Notice. Upon written request, you may obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically.

IX. Effective Date. This Notice is effective as of April 14, 2003.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of Clark Hearing, INC Notice of Privacy Practices.

I have read and understand the Notice and I have had an opportunity to ask questions about the use and disclosure of my health information, and other concerns regarding my health information.

_____

Printed Name of Patient

_____ _____

Signature of Client (or Personal Representative) Date

_____

Printed Name of Personal Representative (if applicable)