Jagadish M. Swamy, AuD, CCC-A, F-AAA
President | Board Certified Audiologist
Jennifer Larmann, AuD
Board Certified Audiologist

Thank you for choosing Clear Sound Audiology!

Welcome! We look forward to providing you the best hearing healthcare services to be found anywhere!

If you are new to Clear Sound Audiology, included in this packet you will find your initial paperwork, as well as information about our practice.
Please complete these forms and bring them to your first visit, along with your photo ID and insurance cards. Family members are always welcome and even encouraged to join you on your visit. Feel free to call with any questions you may have prior to your visit.
We look forward to meeting you!

Our services include, but are not limited to:

- Comprehensive hearing testing
- Hearing aid evaluation and fitting
- Real ear measurement and verification
- All-make hearing aid repair and check
- Custom swim plugs and musician ear plugs
- Custom noise plugs and ear muffs
- Custom ear molds and monitors
- Assistive listening devices

352-505-6766

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Meet Our Audiologists!

Dr. Jagadish Swamy studied Audiology in India, where he earned his Master's in Speech and Hearing, and a Master's in Linguistics. In 2002, he earned his Doctorate of Audiology from the University of Florida. Dr. Swamy has been a practicing audiologist for 20 years, and is a Board Certified Chief Clinical Audiologist. Dr. Swamy's practice combines advanced technology with extensive audiology training, providing exceptional care.

Dr. Jennifer Larmann received her Doctorate in Audiology from Nova Southeastern University. She received her Bachelor of Science degree in Speech Pathology and Audiology from West Virginia University. Dr. Larmann's passion is improving her patient's quality of life through better hearing by working together to meet their individual goals and needs.

Anna David is a fourth-year extern, finishing her doctoral degree in Audiology from the University of Florida. She also received her bachelor's degree in Communication Sciences and Disorders, with a minor in Communication Studies from the University of Florida. Her clinical experience includes both pediatric and adult diagnostics, hearing aids, bone-anchored devices and cochlear implants. Anna is involved in auditory computation and psychophysics research at the University of Florida.

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DATE: ____/_____/_____ **SCYLE ID:** ___________

DEMOGRAPHIC INFORMATION

PATIENT NAME: ______________________________ **GENDER:** MALE _____ FEMALE____

PREFERRED NAME: ______________________________ **BIRTHDATE:** ______/_____/___________

ADDRESS: ______________________________ **HOME PHONE:** (______) ______ - __________

______________________________ **WORK PHONE:**(______) ______ - __________

EMAIL: ______________________________ **CELL PHONE:** (______) ______ - __________

LEGAL INFORMATION

RESPONSIBLE PARTY: ☐SELF ☐ OTHER: ____________________ RELATIONSHIP: _______________

ADDRESS: ____ PHONE: (______) ______ - ________

______________________________________ E-MAIL: ____________________________________

EMPLOYMENT INFORMATION

EMPLOYMENT STATUS: ☐ FULL TIME ☐ PART TIME ☐RETIRED ☐UNEMPLOYED ☐ACTIVE MILITARY ☐ STUDENT

EMPLOYER:________________________________ OCCUPATION: ________________________

REFERRAL INFORMATION

HOW DID YOU HEAR ABOUT OUR OFFICE? ☐ONLINE ☐3rd PARTY (WORKERS COMP/VOC REHAB)

☐ COUNTY ☐COMMUNITY EVENT ☐ STAFF ☐ ADVERTISING: ______________________

☐ FAMILY/FRIEND: ________________________ *(Are they a patient here?)* ☐ YES ☐ NO

☐ PHYSICIAN: ____________________________ *(Would you like a report sent?)* ☐ YES ☐ NO

MARITAL INFORMATION

MARITAL STATUS: ☐ SINGLE ☐MARRIED ☐DIVORCED ☐PARTNERED ☐WIDOWED ☐OTHER

SPOUSE NAME: ____________________________ IS SPOUSE A PATIENT? ☐ YES ☐NO

EMERGENCY INFORMATION

EMERGENCY CONTACT NAME: ____________________________ RELATIONSHIP: ________________

ADDRESS: ____ PHONE: (______) ______ - ________

PROVIDER INFORMATION

PRIMARY PHYSICIAN: ______________________________ PHONE NUMBER: (______) ______ - ________

PREVIOUS AUDIOLOGIST: ______________________________ PHONE NUMBER: (______) ______ - ________

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SYCLE ID: ____________

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: ______________________________

POLICY/GROUP/MEMBER NUMBER: ____________________ **PLAN NAME:** ____________

RELATIONSHIP TO INSURED: ☐ SELF ☐ OTHER: ____________________

IF 'OTHER' **-NAME:** ____________________ **DATE OF BIRTH:** ____/____/____

PHONE NUMBER: (____) ______-______ **ADDRESS:** ____________________

SECONDARY INSURANCE: ☐ NONE ☐ NAME: ____________________

POLICY/GROUP/MEMBER NUMBER: ____________________ **PLAN NAME:** ____________

RELATIONSHIP TO INSURED: ☐ SELF ☐ OTHER: ____________________

IF 'OTHER' **-NAME:** ____________________ **DATE OF BIRTH:** ____/____/____

PHONE NUMBER: (____) ______-______ **ADDRESS:** ____________________

MEDICATIONS LIST

IF NONE, CHECK HERE: ☐

Name of Medication	Strength/Frequency	Condition Med Taken For	Prescribing Physician

ALLERGIES

IF NONE, CHECK HERE: ☐

____

____

____

Hear now, Hear always.

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CLEAR SOUND AUDIOLOGY

SYCLE ID: ____________

MEDICAL AND HEARING HISTORY	YES	NO
Is this your first hearing test?		
Have you ever had ear surgery?		
Did you have a history of ear infections?		
Do you have family history of hearing loss?		
Do you have a history of noise exposure?		
Have you had any head trauma?		
Do you have diabetes?		
Are you currently taking blood thinners?		
Have you received chemotherapy or radiation treatment?		
Do you have ringing in your ears?		
If so, does it bother you during the day?		
If so, does it keep you awake at night?		
Have you noticed dizziness?		
If so, is it a spinning sensation?		
If so, is it a light-headed sensation?		
Do you think you have a hearing loss?		
If so, does it make you feel self-conscious?		
If so, does it cause problems with your family?		
If so, does it cause problems at your work?		
Do you have difficulty hearing someone who whispers?		
Do you have difficulty understanding in a group?		
Do you have difficulty understanding the radio or TV?		
Do you ask people to repeat themselves?		
Has anyone mentioned that you may have hearing loss?		
Do you have difficulty understanding in a restaurant?		
Do you have difficulty understanding in worship services?		
Do you have difficulty understanding high-pitched voices?		

How long have you noticed hearing loss?

- ○ Less than 1 year
- ○ 1 – 3 years
- ○ 4 – 5 years
- ○ Over 5 years

Why have you decided to have your hearing tested?

- ○ I want to be sure there is no loss
- ○ My family suggested I do this
- ○ I feel my hearing is poor
- ○ I think I need hearing aids
- ○ My employer required it

If we were to find out through the hearing evaluation that you could be helped with hearing instruments, are you ready for that help? YES NO MAYBE

How does your hearing loss make you feel?

- ○ It doesn't really bother me
- ○ I am really missing out
- ○ There are times it is a problem

Please list situations in which you would like to hear and/or understand better (please feel free to use the back too):

____________ ____________ ____________ ____________

On a scale of 1-10, 10 being perfect/normal hearing, how do you rate your own hearing? *(Circle one)*

1 2 3 4 5 6 7 8 9 10

Following is a list of factors to consider when investing in hearing instruments. Please rank these in order of importance to you. Place 1 next to the most important, and so on.

_____ Understanding speech better
_____ Maintenance Expense
_____ Follow Up Care
_____ Comfort
_____ Batteries
_____ Provider
_____ Function in Noisy Places
_____ Cosmetic Appearance
_____ Cost

HEARING AID HISTORY: *Please fill this section out if you have use instruments at some time in the past.*

How many years have you used hearing instruments? ____________ Which ear? RIGHT LEFT BOTH

Who was the manufacturer of your instruments? ______________ Were you satisfied? YES NO SOMETIMES

Are you uneasy wearing hearing instruments? YES NO I've gotten used to it

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Patient Name: ______________________________ Date: ____________________

HIPAA Privacy Agreement

The HIPAA privacy rules give individuals the right to request a restriction of uses and disclosures of their protected health information (PHI).

I wish to be contacted in the following manner (Please check all that apply and provide the phone number(s) or email below):

Home# ___________________________ Work# _________________________________

Cell# ____________________________ Email _________________________________

Okay to leave message with detailed information ☐ Home ☐ Work ☐ Cell ☐ Email

Leave message with call back number only ☐ Home ☐ Work ☐ Cell ☐ Email

I prefer to be contacted regarding appointment reminders in the following manner:

☐ Home ☐ Work ☐ Cell ☐ Email

My protected health information may be released to the following individuals:

Name: _______________________ Relationship: _______________ Phone: ________________

Name: _______________________ Relationship: _______________ Phone: ________________

Name: _______________________ Relationship: _______________ Phone: ________________

Name: _______________________ Relationship: _______________ Phone: ________________

I understand that I have the right to change the above information at any time by completing another form.

I, the undersigned, herby acknowledge receipt of Clear Sound Audiology, Inc. Privacy Notice. The privacy Notice provides detailed information about how Clear Sound Audiology, Inc. and its representatives may use and disclose my confidential information. I understand that Clear Sound Audiology, Inc. has reserved the right to change its privacy practices that are described in the Notice. I also understand that a copy of any revised Notice will be provided to me or made available.

Patient Signature: ___________________________________ Date of Birth: ___________________

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HIPAA Privacy Notice

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. 'Protected health information' is information about you, including demographic information, which may identify you and that related to your past, present, or future physical or mental health or condition and related to health care services.

1. **Uses and Disclosures of PHI:** Your PHI ay be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

2. **Treatment:** We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This include the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

3. **Payment:** Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

4. **Healthcare Operations:** We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity, and National Security, Worker's Compensation, and Inmates.

5. **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization at any time in writing, except to the extend that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

6. **Your Rights:** The following is a statement of your rights with respect to your PHI. You have the right to inspect and copy your protected health information. Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this HIPAA Privacy Notice. You request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of you PHI, you PHI will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively (i.e. electronically. You may have the right to have your physician amend you PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

7. **Complaints:** You may complain to us or to the Secretary of Health and Human Services if you believe that your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before November 10th, 2011. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number 352-505-6766.