Customer Information

Date: ____________________

Full Name: ____

Address (street): ____

City, State, Zip: ____

Phone # w/ area code: Home: ___________________________
Cell: ___________________________

Date of Birth: ________________________________

E-Mail: ____________________________________

How did you hear about Zounds? ________________________________

Reason for Visit: ____

____

Primary Care Physician: ____

Phone Number: ___________________________

- Do we have your permission to send your hearing results to your Primary Care Physician? YES________NO________

Notes:

ZHC: Ally Brownrigg **License: HAD7275**
ZHC: Dawn Auzas **License: HAD5553**

ZOUNDS

Case History

Have you received any medical or surgical treatment for a hearing loss? ☐ Yes ☐ No

If yes, when? __________ Physician/ENT: ________________ Telephone: ______________

Street Address: ______________________ City: ____________ State:_____ Zip: _________

Additional information about treatment: ____

____

Consent for Release of Medical Information

I hereby release Zounds Hearing to provide a copy of my medical record/audiological report to my Physician listed above.

Patient Signature: ____

Amplification History

Have you every worn hearing aids in the past? ☐ Yes ☐ No Type: ________________

Do you currently wear hearing aids? ☐ Yes ☐ No Type: ________________________

If yes, and you could improve 2-3 things about your current hearing instrument, what would they be? ____

____

Communication Profile

How? When? Tell me more! Help me understand! Give me an example. I understand.
(To be discussed with customer and companion)

Who encouraged you to come in today to see a hearing professional? _______________

What sort of things have others said or noticed about your level of communication with them?

____

What sort of things have you noticed about your level of communication with others? ______

____

How long has effective communication been an issue between you and others? __________

____

Are there any other situations or environments where you feel that there is ineffective communication

(Please Circle)

Friends	*Family Members*	*Restaurants*	*Small Groups*	*Background Noise*	*Phone*
Bingo	*Meetings*	*Church*	*Playing Cards*	*TV / Radio*	*Weddings*
Children	*Grandchildren*	*Dinner Party*	*Riding in Car*	*Large Gatherings*	*Music*

ZOUNDS

FDA WAIVER

The Food and Drug Administration ("FDA") has determined that prior to purchasing hearing aids, your best health interest would be served if you had a medical examination by a licensed physician (Preferably one who specializes in diseases of the ear) to check for certain conditions including the following:

1. Visible congenital or traumatic deformity of the ear
2. History of active drainage from the ear within the last 90 days
3. History of sudden or rapidly progressive hearing loss within the last 90 days
4. Acute or chronic dizziness
5. Unilateral hearing loss of sudden or recent onset within the previous 90 days
6. Audiometric air-bone gap equal to or greater than 15 decibels at 500 (Hz), 1000 (Hz), and 2000 (Hz).
7. Visible evidence of earwax (cerumen) or any foreign body in the ear canal
8. Pain or discomfort in the ear

If you have any of the conditions listed above, please consult a licensed physician. If you wish to go forward with your hearing evaluation without obtaining a medical examination by a licenses physician, please confirm this by signing this waiver form.

By signing below, I acknowledge having read the above and clearly understand the contents. I further acknowledge that the FDA has determined that it is in my best health interest to undergo a medical examination by a licensed physician before purchasing hearing aids, and I have chosen not to undergo a medical examination. I also acknowledge that I am 18 years of age or older.

Please Print Name:______________________________

Signature: ______________________________ DATE:____________________

Consultant Signature:________________________ License #: HAD7275
Ally Brownrigg, HAD

Consultant Signature:________________________ License #: HAD5553
Dawn Auzas, HAD

HIPAA ACKNOWLEDGEMENT FORM

ZOUNDS HEARING, INC.

I acknowledge that I have received a copy of the Zounds Notice of Privacy Practices.

____________________________ ____________________________

Signature Date

Request and release to share the hearing report with customer's physician

Many of our clients would like us to share their hearing test results with their family physician. If you would like for Zounds Hearing to provide a report to your physician based on today's evaluation, please fill in the information below, sign and date it.

I hereby request and authorize Zounds Hearing to provide a report on my hearing evaluation to my personal physician.

Physician Name

____

Physician Address

____

____

Physician Phone ________________ Physician Fax ______________________

Client Name ______________________________

______________________ _________________________________

Client Signature Date

Please return the pad once complete. Thank you!

This Notice of Privacy Practices is effective beginning December 1, 2006, and shall be in effect until a new Notice of Privacy Practices is approved and posted.

HIPAA

Notice of Privacy Practices
For

Zounds Hearing, Inc.

9365 S McKemy St. Suite 105
Tempe, AZ 85284
480.813.8400

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

PLEASE READ CAREFULLY

For Further Information

Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice or to the **Zounds HIPAA Privacy Officer** at:

Zounds Hearing, Inc.
9365 S. McKemy St. Suite 105
Tempe, AZ 85284
480.813.8400

Zounds Duties

Zounds is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how Zounds keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. As part of **Zounds** legal duties this Notice of Privacy Practices must be given to you. **Zounds** is required to follow the terms of the Notice of Privacy Practices currently in effect.

Zounds may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on the **Zounds** website at www.ZoundsHearing.com and will be available at all Zounds sales locations.

Uses and Disclosures of your Protected Health Information

Protected health information includes demographic and medical information that concerns the past, present, or future health of an individual. Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person.

Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. **Zounds** acts as a health care provider, a medical product manufacturer, and is also an employer. This medical information is used by **Zounds** in many ways while performing normal business activities.

Your protected health information may be used or disclosed by **Zounds** for purposes of providing **Zounds** products, services, and payment. Your protected health information may be shared, with or without your consent, with another health care provider for purposes providing **Zounds** products, services and payment. **Zounds** may send the medical information to insurance companies, financial companies, Medicaid, or community agencies to obtain payment for the services provided to you.

Unless you notify **Zounds** that you object, **Zounds** may provide your health information to individuals such as family and friends, who are involved in your hearing health. **Zounds** may do so if you tell **Zounds** to do so, or if you know **Zounds** is sharing this information and you do not stop **Zounds** from doing so. Your information may be used by certain **Zounds** personnel during audits and investigations to improve operations. **Zounds** also may send you appointment reminders and information about other health-related benefits and services.

Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- Government investigations and audits
- Public health purposes including vital statistics, disease reporting, public health surveillance, investigations, interventions and regulation of health professionals
- Court orders, warrants, or subpoenas
- Law enforcement purposes, administrative investigations and judicial administrative proceedings

Other uses and disclosures of your protected health information by the department will require your written authorization. This authorization will have an expiration date that can be revoked by you in writing. These uses and disclosures may be for marketing and for research purposes.

Individual Rights

You have the right to request Zounds to restrict the use and disclosure of your protected health information to provide Zounds products, services, and payment. You may also limit disclosures to individuals. **Zounds** is not required to agree to any restriction.

You have the right to be assured that your information will be kept confidential.

Zounds may mail or call you with appointment reminders. We will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. You may provide an address other than your residence where you can receive mail and where we may contact you.

You have the right to inspect and receive a copy of your protected health information.

Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law. If access is denied, you have the right to request a review by a licensed hearing professional who was not involved in the decision to deny access. This licensed hearing professional will be designated by **Zounds.**

You have the right to correct your protected health information.

Your request to correct your protected health information must be in writing and provide a reason to support your request correction. **Zounds** may deny your request, in whole or part, if it finds the protected health information:

- Was not created by **Zounds**
- Is not protected health information
- Is by law not available for your inspection, or
- Is accurate and complete

If your correction is accepted, **Zounds** will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. **Zounds** will respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

You have the right to receive a summary of certain disclosures.

Zounds may have made of your protected health information. This summary does **not** include:

- Disclosures made to you
- Disclosures to individuals involved with your hearing health care
- Disclosures authorized by you
- Disclosures made to provide Zounds products, services, and payment
- Disclosures for public health
- Disclosures for health professional regulatory purposes

This summary **does** include disclosures made for:

- Purposes of research, other than those you authorized in writing
- Responses to court orders, subpoenas, or warrants

You may request a summary for not more than a 6-year period from the date of your request.

If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the **Zounds HIPAA Privacy Officer** and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201/ telephone 202-619-0257 or toll free at 877-696-6775. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. **Zounds** will not retaliate against you for filing a complaint.

Effective Date