HEAR2UNDERSTAND
AUDIOLOGY SERVICES

1112 MORGAN AVE. BAY B SASKATOON, SK S7H2R7
PHONE 306-716-7143 FAX 306-384-4184

PERSONAL INFORMATION FORM

FIRST NAME:_____

LAST NAME:_____

BIRTHDATE (dd/mm/yyyy):_____AGE:_____

PRONOUNS: SHE/HER HE/HIM THEY/THEM OTHER:_____

PARENTS/GUARDIANS (if applicable):_____

_____

ADDRESS:_____

CITY/TOWN:_____POSTAL CODE_____

HOME/CELL PHONE:_____

WORK PHONE (optional):_____

EMAIL (optional):_____

3RD PARTY ID# (VAC/NIHB/SHP/WCB):_____

Provincial Health Card #:

SIGNATURE:_____ DATE: _____

(IF SIGNED BY PARENT/GUARDIAN/NEXT OF KIN:_____)

(PLEASE PRINT NAME)

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CONSENT TO COLLECT PERSONAL INFORMATION & CONSENT TO TREATMENT

OUR COMMITMENT TO PRIVACY

The appropriate collection, use and disclosure of clients' personal health information is fundamental to our operations and to your care. We strive to provide you with excellent hearing health care and services, which includes treating your personal information with respect. Each employee of Hear2Understand Audiology Services must abide by our commitment to privacy in the handling of personal information.

CONSENT TO COLLECT INFORMATION

I have read and understood the privacy policy statement located on the back of this form that outlines how my personal information will be collected, used, disclosed and protected. I understand my rights to review this personal information, which will be used to provide me with hearing services. In some instances, I may ask for specific information not to be collected. I understand that the Audiologist in her discretion may make use of all other records that would permit her to complete the investigation and follow-up regarding my hearing status.

CONSENT TO TREATMENT

I also consent to undergo all hearing-related exams and procedures by the professional staff at Hear2Understand Audiology Services

Signature: _____ **Date** _____

Print Name: _____

CONSENT FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

I hereby authorise Hear2Understand Audiology Services to disclose copies of the health record (audiograms, reports, etc.) and conduct other necessary correspondence related to the hearing health care of:

CLIENT/PATIENT NAME:

_____ **DOB:** _____

TO: *(please provide name and phone number if possible)*

☐ Next of Kin / Family member(s) / POA

_____

☐ Physician(s)_____

☐ ENT/Otologist _____

☐ SLP_____

☐ School / Teacher _____

☐ Travel Coordinator_____

☐ Other_____

Third Party:

☐ FIHP ☐ NIHB ☐ SHP ☐ VAC ☐ WCB

I ACKNOWLEDGE THAT THIS INFORMATION IS CONFIDENTIAL. I ACCEPT THE RESPONSIBILITY FOR THE SAFEKEEPING OF THIS INFORMATION. HEAR2UNDERSTAND AUDIOLOGY SERVICES, ITS AGENTS AND EMPLOYEES ARE RELIEVED OF ANY RESPONSIBILITY RESULTING FROM REPRODUCTION OR FURTHER USE OF THE INFORMATION RECEIVED OTHER THAN STATED ON THIS FORM.

This consent must be signed by the client/patient or their legal next of kin in accordance with Health Information Protection Act (HIPA) legislation.

_____ _____

Signature **Relationship to Client/Patient**

Date: _____

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PERSONAL COMMUNICATIONS CONSENT

Client Name: _____

Parents/Guardians (if applicable): _____

Email Addresses: _____

I request and authorize Hear2Understand Audiology Services to communicate information with me regarding aspects of my hearing healthcare as follows. **SELECT ALL THAT APPLY**:

- ☐ Fax a copy to my physician(s) listed
- ☐ Email me a password protected copy
- ☐ I will pick up a copy of my report
- ☐ I do not require a personal copy of my report at this time.

I agree that Hear2Understand Audiology Services shall not be liable for any type of damage or liability arising from or associated with the loss of confidentiality due to email or fax communication that is not caused by the hearing health care provider's intentional misconduct. I understand Hear2Understand Audiology Services will use reasonable means to protect the security and confidentiality of email information sent and received. Further I understand Hear2Understand Audiology Services does not guarantee these means of communication will be free from technological difficulties including, but not limited to, loss of messages or delay of transmission.

This authorization for communication by means of email or fax is valid until I notify Hear2Understand Audiology Services, in writing, that I no longer authorize the use of email to communicate information concerning my hearing healthcare. Hear2Understand Audiology Services also retains the right to terminate email or fax as a communication option if it is not used appropriately.

My signature below indicates I accept the risk of loss of privacy of confidential health information associated with email or fax communication.

Signature:_____ **Date**:_____

If signed by parent/guardian/next of kin (please print):_____

AUDIOLOGY CASE HISTORY FORM

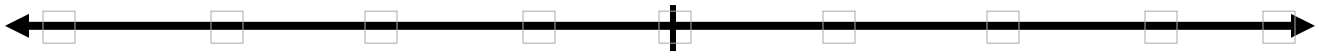
Name: _____ Date:_____

Presenting Problem

1. What is your primary complaint about your ears or hearing? _____
2. What do you think caused your hearing problem? _____
3. If you have a hearing loss, how long have you noticed this? _____
4. Which is your worse ear (if they are different): Left ____ Right ____
5. Do you have difficulty understanding:

   TV: Yes____ No____ Telephone: Yes____ No____ In groups: Yes ____No____

6. How important is it for you to improve how you hear, understand, or communicate with others RIGHT NOW (mark on the line)



0 10
(Not at all important) (Extremely important)

History

1. Have you had your hearing tested before? Yes____ No____ If yes, when and where?:

_____

2. Any drainage from the ear within the past 90 days? Yes____ No____
3. Have you experienced any dizziness, balance problems, or falls? Yes____ No____
4. Have you had any pain/discomfort in your ears within the past 90 days: Yes____ No____

   If yes, rate your pain on a scale of 0 (no pain) to 10 (worst pain possible) _____

5. Have you ever lost hearing in one ear *suddenly*? Yes____ No____
6. Do you have any noises or ringing in your ears? Yes____ No____ left/right/both

   If present, is it: Constant ____Intermittent ____ When did you first notice it? _____

7. Have you received any medical or surgical treatment for hearing loss? Yes____ No____
8. Do you have trouble with arthritis, stiffness, numbness in your fingers? Yes____ No____

*****TURN OVER TO BACK PAGE*****

9. Have you ever been exposed to loud noise? Military Occupation/Job Recreational

   If yes, describe the type of noise: _____

   Did you use ear plugs/muffs? Yes____ No____

10. Is there a history of hearing loss in your immediate family? Yes____ No____

    If yes, who: _____

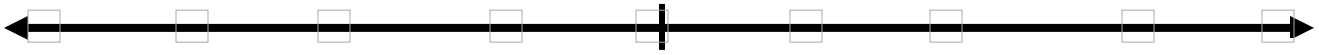
11. Medical problems (check all that apply):

    Infectious disease ____ Diabetes ____ Heart problems ____ Head injury ____
    High blood pressure ____ Headache ____ Kidney failure ____
    Pacemaker/Defibrillator ____
    Other (please explain): _____

12. Have you ever worn a hearing aid(s)? Yes ____ No ____

    If yes, how would you rate your experience with your hearing aid(s) on a scale of 0 (terrible) to 10 (great)? ____

13. How confident are you in your own ability to use and take care of hearing aids if they are recommended? (mark on the line)



0 (Not at all confident) 10 (Extremely confident)

14. In what situations would you most like hearing aids to help you (if recommended)?:
    Conversations with family or friends ____ TV ____ Telephone ____ In the car ____
    Places of worship ____ Music ____ Other: _____

15. Select all that apply:
    ____ I am not ready for hearing aids at this time.
    ____ I have been thinking that I might need hearing aids.
    ____ I have started to seek information about hearing aids.
    ____ I am ready to wear hearing aids if they are recommended.
    ____ I am comfortable with the idea of wearing hearing aids.
    ____ I currently wear hearing aids.

Comments or questions for the audiologist:

_____

_____

_____

_____

10 PRINCIPLES OF PRIVACY

Principle 1 – Accountability: We take our commitment to securing your privacy seriously. The staff associated with this practice is responsible for the personal information under its control. Staff are informed about the importance of privacy and receive information periodically to update them about our Privacy Policy, confidentiality, and related issues.

Principle 2 – Identifying Purposes: *Why we collect information* – We ask for personal information to establish a relationship and to serve your medical needs. We obtain most information directly from you or from other health practitioners whom you have seen and have authorised to disclose information to us. We will limit the information that we collect and will use it only for those purposes. We will obtain your consent if we wish to use your information for any other purpose.

Principle 3 – Consent: For most health care purposes your consent is implied due to your consent to treatment, however sometimes written consent may be required.

Principle 4 – Limiting Collection: We only collect information for purposes related to the provision of your medical care.

Principle 5 – Limiting Use, Disclosure, and Retention: We will seek your consent before using the information for purposes beyond the scope of our privacy statement. Under no circumstances do we sell patient lists or other personal information to third parties.

Principle 6 – Accuracy: While we do our best to base our decisions on accurate information, we rely on you to disclose all material information and to inform us of any relevant changes.

Principle 7 – Safeguards: *Protecting your information* – The practice maintains personal information in a combination of paper and electronic files. Recent paper records concerning individuals' personal information are securely stored in files held onsite in our office. If required, older records may be stored offsite. Only authorised personnel will be granted access to these private records.

Principle 8 – Openness: *Keeping you informed* – If you have any additional questions or concerns about privacy, please ask. We would be more than happy to give you more details upon your request.

Principle 9 – Individual Access: We will give you access to the information we retain about you within a reasonable time. We may charge a fee for this and if so, we will give you notice in advance of processing your request. Please note, we are not required to correct information relating to clinical observations or opinions made in good faith.

Principle 10 – Challenging Compliance: We encourage you to contact us with any questions or concerns you might have about our Privacy Policy. If you are still not satisfied we can provide further complaint procedures available to you.

These principles are usually referred to as "fair information principles". They are included in the *Personal Information Protection and Electronic Documents Act* (PIPEDA), Canada's private-sector privacy law.