MANHATTAN AUDIO, INC.
34 EAST 67TH STREET, SUITE 4F
NEW YORK, N.Y. 10065
(212) 628-2710
FAX (212) 628-3580

PATIENT PROFILE

DATE _____

PATIENT NAME

LAST_____ FIRST_____

DATE OF BIRTH _____/_____/_____ SEX OF PATIENT - MALE_____ FEMALE_____

ADDRESS _____APT_____

CITY_____ STATE_____ ZIP _____

HOME# _____ WORK# _____ CELL# _____

SOCIAL SECURITY# _____-_____-_____ E-MAIL ADDRESS_____

SINGLE MARRIED PARTNER WIDOWED OTHER_____

*****IF YOU WOULD LIKE TO RECEIVE ROUTINE AND FOLLOW UP REMINDERS PLEASE CHECK_____**

INSURANCE INFORMATION

PRIMARY INSURANCE _____

POLICY HOLDER NAME _____ DATE OF BIRTH_____/_____/_____

PATIENT RELATION TO POLICY HOLDER _____ MALE_____ FEMALE_____

ID# _____ GROUP # _____

POLICY HOLDER ADDRESS_____

SECONDARY INSURANCE _____

POLICY HOLDER NAME _____ DATE OF BIRTH_____/_____/_____

PATIENT RELATION TO POLICY HOLDER _____ MALE_____ FEMALE_____

ID# _____ GROUP # _____

REFERRED BY

NAME _____PHONE # _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

Please circle

Would you like to receive promotional or educational literature regarding new hearing products? Yes/ NO

Manhattan Audio, Inc.
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Case History

Name: _____ **Date:** _____

When was your last hearing test? _____
Name of the doctor who last tested you? _____ **Tel#**_____

Hearing Loss:
Right Ear Left Ear Both

Tinnitus: (Ringing in the ear, buzzing or hissing)
Right Ear Left Ear Both

Ear Pain:
Right ear Left Ear Both

History of ear infection or Ear Surgery:
Right ear Left Ear Both

Family history of Hearing Loss? Yes/No
Who? _____

Dizziness/Lightheadedness Yes/No

Vertigo(Spinning sensation) Yes/No

History of Noise Exposure Yes/No

History of Jaw pain Yes/No

Covid 19 Infection Yes/No if yes, when_____
Covid Vacinne Yes/No if yes, when_____

Medications: List below

_____
_____
_____
_____
_____
_____
_____

Manhattan Audio Inc.

34 East 67th Street, New York, NY 10065
Tax I.D. #81-2638387
Medicare Group #MAW101
Corporate NPI # 1902255581

Patient's Name: _____ _____ _____
(First) (Last) Date of Birth

X_____ Date_____
Signature required:

Assignment of benefits: I hereby assign my benefits to be paid directly to the undersigned Audiologist. I understand that I am financially responsible for non-coverage services, as well as deductibles, and/or co-pays.

92557 - Basic CAE	$110.00
92570 - Impedance Audiometry (Includes Decay)	$90.00
92550 - Impedance Audiometry (Without Decay)	$65.00
99483- Quicksin and Cognivue Thrive cognitive screening***	$75.00
92588 - Otoacoustic Emissions (12 frequencies w/report)	$175.00
92540 – VNG	$370.00
92537 - Caloric Testing 4 units	$260.00
92538- Caloric Testing 2 units	$130.00
92653 - Auditory Evoked Potentials (ABR)	$375.00
92552 - Pure Tone (air only)	
92553 - Pure Tone (air/bone)	
92555 - Speech Audiometry (threshold only)	
92556 - Speech Audiometry (threshold/speech recognition)	

Referring Physician: _____

Diagnosis Codes: _____

Levels: Left_____ Right _____

Type: Left_____ Right _____

Audiologist Signature: _____

Please do not write below this line for Billing only:
Copay Collected $_____
Claim# _____
Date:_____
Ingrid Mercado

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice, which is posted in our waiting room, before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review the Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

Patient Name: _____

Signature: _____

Date: _____

For patient under the age of 18 years old- The Consent was signed by:

X_____ Relation to child: _____