POTOMAC RIVER CLINIC

Dear Prospective Patient,

Thank you for your interest in Potomac River Clinic. Information regarding our program is enclosed along with forms that should be completed and returned prior to your first appointment.

Please include any relevant background information or reports that may assist us better in understanding yourself.

We require the full COVID vaccine series for all those eligible (i.e., all patients 6 months and older) for in-person services.

All correspondence should be emailed to intake@potomacriverclinic.org or sent to:
Intake Coordinator
Potomac River Clinic
4880 MacArthur Blvd, NW
Washington, DC 20007

If you have any questions, please do not hesitate to contact us at 202-333-1403 or by email at intake@potomacriverclinic.org

Sincerely yours,

Meredith Ouellette
Director of Clinical Services
Potomac River Clinic

POTOMAC RIVER CLINIC

Adult Case History

General Information

Client Name:	Gender: ☐Male ☐Female ☐Non-Binary ☐Prefer not to disclose
DOB:	Pronouns: ☐He/Him ☐She/Her ☐They/Them ☐Other:
Mailing Address:	
Phone #:	Occupation:
Email:	

How did you hear about Potomac River Clinic?: _____

Reason for visit: _____

Primary Care Physician: _____ Primary Care Phone #: _____

ENT Physician: _____ ENT Phone #: _____

Medical History

Have you had or been diagnosed with any of the following:

Abnormal Blood Pressure	☐Yes	☐No	Kidney problems	☐Yes	☐No
Allergies	☐Yes	☐No	Migraines	☐Yes	☐No
Asthma	☐Yes	☐No	Neurological impairment	☐Yes	☐No
Bone/Joint issues	☐Yes	☐No	Seizures	☐Yes	☐No
Cancer	☐Yes	☐No	Sinus issues	☐Yes	☐No
Depression/Anxiety	☐Yes	☐No	Sleep disorder	☐Yes	☐No
Diabetes	☐Yes	☐No	Thyroid	☐Yes	☐No
Ear Infections	☐Yes	☐No	Urinary issues	☐Yes	☐No
Ear Surgery	☐Yes	☐No	Vision problems	☐Yes	☐No
Head trauma/injury	☐Yes	☐No	Genetic Testing Completed	☐Yes	☐No

If “yes” to any of the above, please explain and include onset, duration, and medications:

Hearing/Audiological History

What is your better or preferred ear? (typically used for the phone) ☐Right ☐Left

Was your hearing loss gradual or rapid onset? ☐Gradual ☐Rapid

Do you have or experience any of the following:

History of noise exposure	☐Yes	☐No	Fluctuations in hearing	☐Yes	☐No
Tinnitus (ringing) in ears	☐Yes	☐No	Difficulty hearing in noise	☐Yes	☐No
Sensitivity to loud sounds	☐Yes	☐No	Difficulty listening to the TV	☐Yes	☐No
Fullness in ears	☐Yes	☐No	Difficulty talking on the telephone	☐Yes	☐No
Discharge in ears	☐Yes	☐No	Family history of hearing loss	☐Yes	☐No
Pain in ears	☐Yes	☐No	Limit activities due to hearing loss	☐Yes	☐No
Dizziness/vertigo	☐Yes	☐No	Hearing loss affecting occupation	☐Yes	☐No

If “yes” to any of the above, please explain and list worse ear if applicable:

POTOMAC RIVER CLINIC

Have you had a full hearing evaluation before? ☐Yes ☐No

If "yes", please attach a copy of the results and indicate the following below: clinic name, audiologist, test date and results

Hearing Aids

If you currently use hearing aids (HA), please complete the following section. If not, please skip.

Right Ear

Fitting Date:	
Audiologist:	
Clinic:	
HA Manufacturer:	
HA Model:	
Date of last programming:	

Left Ear:

Fitting Date:	
Audiologist:	
Clinic:	
HA Manufacturer:	
HA Model:	
Date of last programming:	

Cochlear Implants

If you use cochlear implants (CI), please complete the following section. If not, please skip.

Right Ear

Implant Center:	
Surgery Date:	
Surgeon:	
Activation Date:	
Audiologist:	
CI Manufacturer:	
CI Processor:	
Internal Device:	
Date of last programming:	

Left Ear

Implant Center:	
Surgery Date:	
Surgeon:	
Activation Date:	
Audiologist:	
CI Manufacturer:	
CI Processor:	
Internal Device:	
Date of last programming:	

If you have previously worn hearing aids or cochlear implants, please list the make and model, length of use, and reason for discontinuing use:

Are you open to hearing aids, cochlear implants, or other amplification devices if deemed appropriate?

Statement of Nondiscriminatory Policy

Potomac River Clinic admits individuals of any race, color, and national or ethnic origin to the rights, privileges, programs, and activities it provides. The following information is optional and is used to collect statistical data.

Patient's race (optional): _____

Patient's ethnicity (optional): _____

POTOMAC RIVER CLINIC

INSURANCE INFORMATION and BILLING POLICIES

Client's Name: _____ Date of Birth: _____
Sex Assigned at Birth:☐Male☐Female

****PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD, including the front and back of card**

Insurance	Primary	Secondary
Company Name		
Subscriber's Name		
Subscriber's DOB		
Insurance Mailing Address		
Member ID #		
Group #		
Provider's Phone #		

BILLING

Services are billed monthly and can be paid by cash, check, or credit card. A $25 service charge will be added for any returned checks. Potomac River Clinic will bill insurance companies on your behalf. Potomac River Clinic reserves the right to terminate a contract due to non-payment or repeated late payment.

CANCELLATION POLICY

If you fail to cancel an appointment 24 hours in advance of your scheduled appointment, you will be billed the full amount of the visit. If your child becomes ill unexpectedly (e.g., during the school day), please notify us immediately for the absence to be considered excused. Our cancellation policy enables us to provide quality care, keep our charges reasonable, and retain our excellent staff.

SNOW AND EMERGENCY CLOSING POLICY

Potomac River Clinic will follow The River School inclement weather policy.

SUSPENSION AND TERMINATION POLICY

Potomac River Clinic reserves the right to suspend services at any time and at its discretion.

Please read carefully and sign below. I authorize Potomac River Clinic to bill directly my/our insurance for services and/or durable medical equipment (DME) rendered. I understand that if an insurance payment is not received within 90 days of billing, Potomac River Clinic will bill me for the amount, which will become due immediately. If I pay the charges and an insurance payment is received at a later date, Potomac River Clinic will credit my account and issue a refund. I understand that, under certain circumstances, services may be suspended until an overdue account is settled.

Signature of Client or Parent/Guardian: _____

Name (Print): _____ Today's Date: _____

POTOMAC RIVER CLINIC

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We, Potomac River Clinic, are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect July 1, 2021, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us by using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about your for treatment, payment, and health care operations. The following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes 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. We will also disclose your protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you and your have been referred, to ensure that the physician has the necessary information to diagnose or treat your.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name as the parent or guardian of your. We may also call you by name in the waiting room when your doctor is ready to see you and your. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail a reminder to you regarding your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you and your health and/or treatment. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you and your. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by contacting us by using the information listed at the end of this notice.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events; product defects or problems or biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to law enforcement officials concerning the protected health information of a suspect, fugitive, material witness, crime victim, or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address listed at the end of this notice. If you request copies, we will charge you $25.00 for each page or $10.00 per hour to locate and copy your protected health information, and postage if you want the copies mailed to you. If you would prefer, we will prepare a summary or an explanation of your protected health information for a fee. Please contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which Potomac River Clinic or our business associates disclosed your protected health information for purposes other than for treatment, payment, health care operations, and certain other activities after April 14, 2003. After April 14, 2009, the accounting will be provided to you for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Please contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below. If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Meredith S. Ouellette, Privacy Officer, Potomac River Clinic
4880 MacArthur Blvd., NW
Washington, DC 20007
(202) 337-3554

POTOMAC RIVER CLINIC

NOTICE OF PRIVACY PRACTICES

SIGNATURE PAGE

I, (Print Name) _____, have received the Notice of Privacy Practices on (Date) _____, given to me by Potomac River Clinic. If I have any questions, or concerns, I realize that I can contact Meredith Ouellette, Potomac River Clinic's Privacy Officer, at 202-337-3554.

_____ _____

Signature Date