AMERICAN ACADEMY OF AUDIOLOGY

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Patient Record Content

The audiological record is a legal document containing information relative to medical and social history, evaluation results and interpretation, recommendations, continuity of care, case management, and peer review accountability. The Academy's Code of Ethics (5e) states "Individuals shall maintain accurate documentation of services rendered according to accepted medical, legal and professional standards and requirements." The record shall contain sufficient documentation to comply with the following (but not limited to): Federal and State regulatory statutes and compliance standards, licensing regulations, insurance requirements, necessary components required by contract negotiations, and requirements for medical electronic records for audiology practice settings.

The following elements may be included in the documentation in a patient's medical record. Audiologists should consult with their attorney or employer to determine which elements are required for their individual practice locations.

1. **Demographic information**
    a. Name
    b. Address
    c. Date of birth
    d. Contact information
    e. Emergency contact information
    f. Medical Record Number, if applicable

2. **Insurance and other Information**
    a. Copy of health insurance card(s), front and back
    b. Physician order, if required (e.g., Medicare)
        i. Referring physician
    c. Driver's license with photo or other proof of identity
    d. Notice of Privacy Practices
    e. Power of attorney when indicated
    f. Health Care Proxy when indicated
    g. Permission to treat if patient is under 18 and unaccompanied by parent/caregiver
    h. Consent to treat
    i. Consent for any authorizations
    j. Consent to contact insurance company and bill insurance company (ies)
    k. Release of information, if required
    l. Advanced Beneficiary Notice (ABN) for Medicare
    m. Insurance waiver for commercial payers for non-covered services

3. **Case history**
    a. Reason for visit-chief complaint

b. Family history
c. Adults-case history form
    i. Surgeries
    ii. Medications and general medical history
    iii. Occupational history
    iv. Recreational history
    v. Fall history
d. Pediatrics and Adolescents-case history form
    i. Pregnancy and delivery
    ii. Surgeries
    iii. Medications and general medical history
    iv. Occupational history
    v. Recreational history
    vi. Fall history
e. Other:
    i. Requirements of Physician Quality Reporting System for Part B Medicare beneficiaries:
        1. List of current medications
        2. Depression screening and follow up recommendations
        3. Other requirements

4. Audiometric or vestibular tests

a. Patient name
b. Date of service
c. Audiologist's signature (including electronic signatures) If a student or assistant participated in the patient's visit, this should be documented
d. Report of test(s) performed and results
e. Recommendations/clinical judgments
f. Copies of all tests to be included in record
g. Make and model of audiometer
h. Most recent calibration date of audiometer
i. Reliability rating (good/fair/poor)
j. Earphones (insert or TDH-39)
k. Testing method (conventional, behavioral, and/or conditioned play)
l. Self-assessment questionnaires (e.g., depression, functional communications, APHAB, COSI, tinnitus questionnaires)

5. Hearing aid(s)

a. Medical clearance or waiver
b. Waiver for upgrade in hearing aid technology above covered benefit
c. User instructional brochure provided
d. Hearing aid checklist
    i. Instructions on insertion, removal, controls
    ii. Battery insertion, removal and disposal
        1. Include battery ingestion hazards
e. Hearing aid insurance waivers

f. Binaural waiver
g. Earmold impression waiver
h. Forms for demos, loaners, and/or repairs

6. **Coding**
    a. CPT, HCPCS and/or ICD-9/10 codes should reflect the services provided, the diagnosis/diagnoses

7. **Other:**
    a. Letter to referral source listing tests performed, their findings and recommendations
    b. Correspondence (e.g., notes of phone calls, encrypted e-mails, faxes, etc.)
        i. Texting is not secure or HIPAA compliant-must be encrypted!
        ii. Office policy for texting and e-mail
        iii. Cyber insurance
    c. Reports from other providers

General rules for a hard copy chart:

- Information must be secured and legible; no sticky notes!
- If an error is made, strike through with one line, date and initial; do not scribble
- Shred any unneeded information that has personal health identifying information

Note: The American Academy of Audiology has created this fact sheet as a tool and is not representative of all components expected to be included in a patient's medical record. It is intended to provide general information and educational guidance to audiologists. Action taken with respect to information provided is an individual choice. The American Academy of Audiology herby disclaims any responsibility for the consequences of action(s) taken by an individual(s) as a result of using the information provided. As used herein, the "American Academy of Audiology" shall be defined to include its directors, officers, employees, volunteers, members and agents.