HEARING SPEECH + DEAF CENTER

Patient Information

Date _____

Patient's Name _____ Preferred Name _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip _____

Social Security # _____ Home Phone # _____ Cell Phone # _____

Sex _____ Marital Status _____ Email _____

How may we contact you (i.e. appointment reminders)? ☐ Call home / cell (circle) ☐ Text ☐ Email

Employed By _____ Are you a Veteran? ☐ Yes ☐ No

Contact in Case of Emergency/Relationship _____ Phone # _____

Family Doctor _____Phone # _____Referring Doctor _____ Phone #_____

How did you hear about us? _____ # in Household _____

Primary Insurance _____ Insured Policy ID # _____

Insured Name _____ Insured DOB _____ Insured SS# _____

Insurance coverage provided through: ☐ Employer ☐ Individual Policy ☐ Workers Comp. ☐ Auto Accident Policy

Secondary Insurance _____ Insured Policy ID # _____

Insured Name _____ Insured DOB _____ Insured SS# _____

Insurance coverage provided through: ☐ Employer ☐ Individual Policy ☐ Workers Comp. ☐ Auto Accident Policy

If Patient is a Minor

Caregiver #1 _____ DOB _____ Home Phone # _____ Relationship _____

Caregiver #2 _____ DOB _____ Home Phone # _____ Relationship _____

HOUSEHOLD INCOME

- ☐ $0 - $23,760
- ☐ $23,761 - $32,404
- ☐ $32,041 - $40,320
- ☐ $40,321 - $48,600
- ☐ $48,601 - $56,880
- ☐ $56,881 - $65,160
- ☐ $65,161 - $73,460
- ☐ $73,461 - $81,780
- ☐ Over $81,780

RACE

- ☐ Caucasian
- ☐ African American
- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Pacific Islander/Native Hawaiian
- ☐ Multi-Racial

ETHNICITY

- ☐ Non-Hispanic
- ☐ Hispanic

REFERRAL TYPES/CATEGORIES

- ☐ Agency
- ☐ BSVI/BVR
- ☐ Client
- ☐ Employer
- ☐ Friend/Relative
- ☐ VA
- ☐ Hospital/Physician
- ☐ Job & Family Services
- ☐ KBDD
- ☐ Nursing Home
- ☐ Professional
- ☐ School
- ☐ Staff/Board Member
- ☐ Yellow Pages
- ☐ Print/TV/Radio Media
- ☐ HSDC Mailer
- ☐ HSDC Special Event
- ☐ Website
- ☐ OBDD
- ☐ Other

COUNTY OF RESIDENCE

☐ Adams ☐ Boone ☐ Brown ☐ Butler ☐ Campbell ☐ Clermont ☐ Dearborn
☐ Hamilton ☐ Highland ☐ Kenton ☐ Ohio ☐ Warren ☐ Other _____

Do you live in the city of Cincinnati? ☐ Yes ☐ No Do you live in the city of Middletown? ☐ Yes ☐ No

As a member United Way agency, we are required to collect this information. This information is being collected for census reporting only. Your answers will be kept confidential and no identifying information will be shared. No information will be used to determine eligibility for our services.

Please Read and Sign Below

Signature _____ Date _____

If this is a workers compensation visit or auto accident account we must have that information on an additional form. Please ask the receptionist for the appropriate paperwork. Private insurance requires a copay to be paid at the time of services, if applicable.

HEARING SPEECH + DEAF CENTER

General Consent for Care and Treatment

You have the right, as a patient, to be informed about your condition and the recommended evaluation, diagnostic and treatment procedures to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary evaluations, testing and treatments. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any treatment ordered for you. If you have any concerns regarding any treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a health care provider to perform reasonable and necessary evaluation, testing and treatment for the condition which has brought me to seek care at this practice.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____	_____
Signature of Patient/Guardian	**Printed Name of Patient/Guardian**
_____	_____
Relationship to Patient	**Date/Time**
_____	_____
Signature of Witness	**Printed Name of Witness**

Insurance Verification and Change of Coverage Notice

Your insurance information will be requested and verified at each appointment to make sure that we have your most up to date information. This information is requested to avoid any unexpected bills or denials of services. Clients are responsible for notifying the Hearing Speech + Deaf Center of any changes in insurance coverage as soon as possible. Changes in insurance coverage without notice can result in appointment cancelation, denial of service, and/or complete financial responsibility for the services and products rendered becoming the full responsibility of the client.

Change of coverage includes not only a change in the type of insurance, but also insurance provider or a change in the insurance plans.

_____	_____
Signature of Patient/Guardian	**Date**

HEARING SPEECH + DEAF CENTER

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Hearing Speech + Deaf Center to use and disclose **protected health information (PHI)** about me to carry out **treatment, payment and healthcare operations (TPO)**. Hearing Speech + Deaf Center's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Hearing Speech + Deaf Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Hearing Speech + Deaf Center Privacy Official at 2825 Burnet Ave. Cincinnati, OH 45219.

With this consent, Hearing Speech + Deaf Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my hearing or speech services.

With this consent, Hearing Speech + Deaf Center may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Hearing Speech + Deaf Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Hearing Speech + Deaf Center's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Hearing Speech + Deaf Center may decline to provide treatment to me.

The Hearing Speech + Deaf Center has permission to speak to the following regarding my PHI and/or TPO

_____ _____

Name/Relationship Name/Relationship

_____ _____

Name/Relationship Name/Relationship

_____ _____

Signature of Patient/Guardian **Date**

_____ _____

Printed Name of Patient/Guardian **Relationship to Patient**

Acknowledgement Receipt of Notice of Privacy Practices

I have been offered a copy of Hearing Speech + Deaf Center's *Notice of Privacy Practices*.

_____ _____

Signature of Patient/Guardian **Date**

HEARING SPEECH + DEAF CENTER

Agreement to Pay

Thank you for choosing the Hearing Speech + Deaf Center. The Center is a non-profit agency that has been serving the community since 1925. Please review the following policies regarding the payment of fees.

Fees are charged for the professional services rendered to the patient. The patient and/or responsible party accept responsibility for payment. All patients are responsible for notifying the Center immediately of any changes in their insurance policy and for obtaining insurance related referrals and/or authorizations.

If the services rendered are covered by Medicare, Medicaid, private insurance companies, or third party agencies, the Hearing Speech + Deaf Center will verify coverage and file the necessary forms. If payment is not received from a private insurance company within 90 days from the date of submission, the patient will be responsible for payment.

The Hearing Speech + Deaf Center does not deny services to any patient because of documented inability to pay the full cost of services. Persons wishing to apply for a reduced fee should contact the Speech/ Audiology department secretary.

MEDICARE/PRIVATE INSURERS - Your insurance policy is a contract between you and your insurance company. Where Medicare or private insurers do not fully cover services, the patient/family is responsible for the balance. We accept cash, check, American Express, Discover, MasterCard and Visa.

MEDICAID - Medicaid recipients are required to bring their Medicaid card to their first appointment each month.

CANCELLATION/ NO SHOW APPOINTMENTS - A fee of $35.00 may be assessed for No Show appointments and cancellations of appointments with less than 24 hour notification.

The Hearing Speech + Deaf Center reserves the right to discontinue services for non-payment of fees.

I have read the above statement and understand the Hearing Speech + Deaf Center's policies regarding the payment of fees.

_____ _____

Signature of Patient/Guardian **Date**

Insurance Release

I certify that the information given by me in applying for payment under Medicare (Title WVIII of the Social Security Act) and/or other Medical Insurance is correct.

I hereby authorize the release of any medical information necessary to process any claims submitted on my behalf of the Hearing Speech + Deaf Center.

I request that payment under Medicare and/or any other Medical Insurance be made directly to the Hearing Speech + Deaf Center and authorize them to submit a claim to Medicare and or any other Medical Insurance carrier on my behalf.

_____ _____

Signature of Patient/Guardian **Date**

HEARING SPEECH + DEAF CENTER

MEDICATION LIST

NAME OF MEDICATION	**DOSAGE**	**ROUTE** How is your medication taken (Example: Injection, by mouth, suppository)	**FREQUENCY** How often do you take your medication (Example 3 times a day, twice a week)

HEARING SPEECH + DEAF CENTER

Child Case History

The audiologists/speech-language pathologists/occupational therapists at the Hearing Speech + Deaf Center strive to provide you with the best care possible for your child. We thank you in advance for providing us with detailed information so that we can prepare a comprehensive evaluation based on anticipated needs. **Please do not leave any part blank. If something is not applicable to your child, write N/A.**

Background Information

Patient's Name _____ Preferred Name _____ Date of Birth _____

Sibling(s) Name + Age_____

Who lives in the child's home_____

What languages are spoken in the home (circle the primary language used by the child)_____

Primary concerns: ☐ hearing ☐ speech/language ☐ gross/fine motor (OT)

Why is your child coming for an evaluation at this time? _____

Birth History

Length of Pregnancy in Weeks _____ Any Drug, Alcohol, or Tobacco Using During Pregnancy? _____

Please note any difficulties or complications during pregnancy _____

Type of Delivery (please check one) ☐ vaginal ☐ Caesarean (C-section)

Please note any difficulties or complications with delivery (i.e. breathing, feeding, etc.)_____

Child's Birth Weight _____ Child's Birth Length_____ Treatment Received by Baby or Mother Following Delivery_____

Medical history

Does your child have any known allergies? Y N List_____

Has child been diagnosed with any chronic medical condition, syndrome, etc.? List _____

Check Previous Evaluations or Therapy	Yes	No	When	Where
Hearing Evaluation				
Speech/Language Evaluation				
Speech/Language Therapy				
Reading Therapy				
Writing Therapy				
Vision Test				
Psychological/Educational Evaluation				
Physical Therapy				
Occupational Therapy				
Counseling				
Other				

Please list names and any available contact information for any therapists your child currently sees:_____

_____

Medical Conditions/Treatments Your Child Has Had	Yes	No	Age
Ear Surgery			
Ear (PE) Tubes			
Earaches			
Frequent Colds			
Tonsillitis			
Allergies			
Tonsillectomy/Adenoidectomy			
Head Injury			
High Fever (above 104)			
Meningitis			
Encephalitis			
Measles/Mumps			
Serious Accident			
Convulsions/Seizures			
Digestive Problems			
Other Surgery			
Other			

Has your child been diagnosed with or is there a concern for lead poisoning? _____

General Developmental History

Please list the age (in months), to your best knowledge, when your child reached the following milestones:

Social smile _____ Held head up _____ Sat up without support _____ Pulled up to standing _____

Walked independently_____ Dressed self_____ Fed Self_____ Potty-Trained_____

Did your child mouth toys during infancy? _____

Speech-Language Development History

Please list the age (in months), to your best knowledge, when your child reached the following milestones:

Babbling_____ First Words (no, mommy, doggie)_____ Simple word combinations (me go, daddy shoe)_____

Used simple questions (What's that?, Where's doggie?)_____ Did speech/language development ever stop/slow down? _____

Are there any other children in the family experiencing difficulty with hearing, speech and/or motor problems?

If yes, explain_____

Are you concerned about your child

Stuttering	Y	N	Not Talking	Y	N
Vocabulary	Y	N	Being Misunderstood by Strangers	Y	N
Pronunciation	Y	N	Following Directions	Y	N
Incomplete Sentences	Y	N	Hoarse Voice	Y	N
Voice Too Nasal	Y	N	Sentence Length	Y	N
			Voice Not Nasal Enough	Y	N

Feeding History

Was your child ☐ breast-fed ☐ bottle-fed List any supplements your child is taking_____

Do you feed your child or does he/she feed himself/herself? _____

Does the child use: Open Cup Y N Utensils Y N

Does your child have difficulty with weight gain Y N

Does your child refuse to eat, spit out, or gag on foods based on one of the following characteristics (circle all that apply)

Temperature (hot/cold) Soft/Mushy Foods Crunchy Foods Chewy Foods Food Color Mixed Food Textures

Does your child have difficulty with any of the following (circle all that apply)

Chewing a Variety of Foods Sucking Through a Straw Swallowing a Variety of Foods Foods Falling Out of Mouth

Frequent Choking Food Getting Stuck in Cheeks Drooling While Eating Drooling While Not Eating

Does your child exhibit oral sensitivities or sensory seeking behaviors (circle all that apply)

Examining Objects by Mouthing Gagging/Vomiting Frequently Biting/Chewing of Objects/Clothing Grinding Teeth

How long does your child sit for meals _____ How long does it take your child to eat a meal _____

Hearing History

Do you think your child hears normally Y N Does your child have a known hearing loss? Y N

Have others in child's family (including aunts, uncles, and cousins) had hearing problems before age 50? Y N

If yes, please describe _____

Is there any difference in appearance or function for your child's ear/nose/throat or any other body part? Y N

If yes, please describe_____

Does your child			Wear a Hearing Aid	Y	N
Respond to Soft Sounds	Y	N	Startle to Sudden Sounds	Y	N
Turn TV up Loud	Y	N	Turn in the Direction of Sound	Y	N
Pull/Dig at Ears	Y	N	Watch Your Face When You Talk	Y	N
Seem Inattentive at Home/School	Y	N	Have Trouble Following Directions	Y	N
Complain of Ear Pain	Y	N	Come When Called From Another Room	Y	N
Respond To Calling His/Her Name	Y	N	Misunderstand What People Say	Y	N
Say "What" or "Huh" Frequently	Y	N	Complain of Not Hearing You/Others	Y	N

Behavior Information

Has your child been diagnosed with any of the following conditions (circle all that apply)

Autism Asperger's Syndrome Pervasive Developmental Disorder Sensory Processing Disorder ADD/ADHD

Oppositional Defiance Disorder Post-Traumatic Stress Disorder Conduct Disorder Other_____

Does your child			Get Along With Other Children	Y	N
Sleep Well	Y	N	Cry Often	Y	N
Seem Nervous	Y	N	Have Frequent Tantrums	Y	N
Act Destructively	Y	N	Have Poor Coordination/Clumsy	Y	N
Seem Shy	Y	N	Have Short Attention Span	Y	N

Please list any sensitivities your child has to sound, clothing, touch, food_____

How many hours of sleep does your child get each night_____ Does he/she wake up at all during the night Y N

Does your child take a nap Y N If yes, how long and what time of day_____

Academic History

Does your child attend school or day care Y N If yes, where_____

Does your child currently have an IEP, IFSP, or a 504 plan Y N

If yes, indicate services (i.e. speech, reading, writing, or special behavior)_____

_____

Does your child seem to struggle in any particular subject area_____

Has your child ever been suspended or expelled from a daycare or school_____

Please tell us anything else about your child that will help us get to know him/her and your family_____

_____

_____

***Please remember to attach any supporting documentation from other relevant providers (OT, PT, Counseling, Speech, Hearing, IEPs, etc.)**

HEARING SPEECH + DEAF CENTER

Individual Therapy Attendance Policy

Welcome to Speech and/or Occupational Therapy Services at the Hearing Speech + Deaf Center. We appreciate the confidence you have shown in choosing us as your therapy provider. We will make every effort to schedule appointments that are convenient for you, but we ask that you follow the guidelines below. This will allow us to provide the highest quality treatment and service to all our patients.

1. If you need to cancel an appointment, be sure to notify the office manager 24 hours prior to your appointment time. Understand that due to the nature of speech therapy appointments, we may not be able to reschedule another appointment for you.

2. If you will be late for an appointment, please call to verify your therapist can still see you. If you are 15 minutes late (or more) for an appointment, your appointment may be cancelled.

3. If two (2) appointments are ***missed*** within 30 days and you have failed to notify the office manager, your therapy will be discontinued. You may be returned to our waiting list at the discretion of the Center.

4. If more than two (2) appointments are ***cancelled*** within 60 days, your therapy will be discontinued. If we are able to reschedule an appointment for you, the cancellation will not count against you.

_____ _____

Signature of Patient/Guardian **Printed Name of Patient/Guardian**

_____ _____

Signature of Therapist **Date/Time**

Thank you for taking the time to review our individual therapy attendance policy. We truly believe that this policy is the best way to impress upon the family the importance of consistent attendance at speech therapy. Progress will not occur with frequent interruptions.