HEARING SPEECH + DEAF CENTER

Empowering Communication in Greater Cincinnati

PATIENT INFORMATION

Date _____

Patient's Name _____ Preferred Name _____

Date of Birth _____ Street Address _____

City _____ State _____ Zip _____

Social Security # _____ Home Phone # _____ Cellphone # _____

Sex _____ Marital Status _____ Email _____

How may we contact you (i.e., provide appointment reminders)? ☐ Call Home / Cell (circle) ☐ Text ☐ Email

Primary Language _____ Interpreter Needed? ☐ Yes ☐ No

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 is provided through: ☐ Employer ☐ Individual Policy ☐ Workers' Comp ☐ Auto Accident Policy

Secondary Insurance _____ Insured Policy ID # _____

Insured Name _____ Insured DOB _____ Insured SS # _____

Insurance coverage is 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 _____

RACE

☐ Caucasian/White
☐ African American
☐ Asian
☐ American Indian/Alaska Native
☐ Pacific Islander/Native Hawaiian
☐ Multiracial

ETHNICITY

☐ Non-Hispanic
☐ Hispanic

REFERRAL TYPES/CATEGORIES

☐ Agency
☐ Professional
☐ OOD/BVR
☐ School _____
☐ Current Patient
☐ HSDC Board Member
☐ Employer
☐ HSDC Staff Member
☐ Friend/Relative
☐ Print/TV/Radio Media
☐ VA
☐ HSDC Mailer
☐ Physician
☐ HSDC Special Event
☐ Job + Family Services
☐ Website
☐ Nursing Home
☐ Other _____

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Signature _____ Date _____

If this is a workers' compensation visit or an auto accident account, we must be given that information on an additional form. Private insurance requires a copay to be paid at the time of services, if applicable.

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AGREEMENT TO PAY / INSURANCE RELEASE FORM

Thank you for choosing Hearing Speech + Deaf Center (HSDC) as your provider of services. We appreciate the opportunity and privilege of participating in your care. With respect to payment of services, please review the following policies.

- Fees are charged for the professional services rendered. You, as the responsible party, accept complete financial responsibility for payment of all services provided.
- You are expected to pay all deductibles, co-pays, co-insurance amounts and non-covered services at the time of service. We will bill your insurance company for all covered services.
- You are financially responsible for payment in full for any services that are denied as a non-covered service, not medically necessary, if you failed to notify us of changes in insurance coverage or if you did not obtain a referral or authorization as required by your insurance company.
- You are responsible for notifying HSDC immediately of any changes in your insurance policy and for obtaining insurance-related referrals and/or authorizations.
- If payment on a claim we submit is not received from Medicare, Medicaid, private insurance companies, or other third-party payers within 90 days, you are responsible for payment of the balance in full at that time. If your insurance company makes a payment after 90 days, you will be issued a refund within 30 days of payment equal to the amount paid by the insurance company.
- If HSDC is not a participating provider (out of network) with your insurance company, you are responsible for payment in full at the time of service. We will submit a claim to your insurance company on your behalf. If your insurance company makes a payment on the claim, you will be issued a refund check within 30 days of receipt of payment equal to the amount paid by the insurance company.
- HSDC may release patient information to third-party payers and anyone assisting us in obtaining payment, including billing, coding and collection agents and to the provider's attorneys and consultants.
- HSDC reserves the right to discontinue services if you do not pay for your services.
- I understand that HSDC cannot guarantee payment from participating insurance providers for services. Therefore, if my insurance carrier denies payment, I agree to be fully responsible for payment.
- I request that payment under my third-party payer(s) be made directly to HSDC, and I authorize them to submit a claim to the third-party payer(s) on my behalf. I understand and agree to HSDC's policies as stated here.
- A fee of $65 may be assessed for no-show appointments and cancellations of appointments with less than 24 hour notice.

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

Responsible Party Signature _____

Date _____

HEARING SPEECH + DEAF CENTER

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GENERAL CONSENT FOR CARE AND TREATMENT

- As a patient, you have the right 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 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 to discontinue services at any time.
- 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 that 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 _____

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). HSDC'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. HSDC 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 the HSDC Compliance Officer at 2825 Burnet Ave., Cincinnati, OH 45219.

- With this consent, HSDC may call my home or other alternative location and leave a message on voicemail 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, HSDC may 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 HSDC 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 HSDC'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, HSDC may decline to provide treatment to me.
- The Hearing Speech + Deaf Center has permission to speak to the following regarding my PHI and TPO:

Name/Relationship _____

Name/Relationship _____

Signature of Patient/Guardian _____

Printed Name of Patient/Guardian _____

Relationship to Patient _____

Date _____

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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)*

HearingSpeechDeaf.org

Main office:
2825 Burnet Ave., Suite 330
Cincinnati, OH 45219

(513) 221-0527
Video phone (513) 206-9424
Fax (513) 221-1703

Eastgate office:
4440 Glen Este-Withamsville Rd., Suite 475
Cincinnati, OH 45245

(513) 947-8470
Fax (513) 947-8428

West Chester office:
5900 West Chester Rd., Suite J
West Chester, OH 45069

(513) 942-3350
Fax (513) 881-5911

HEARING SPEECH + DEAF CENTER

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INDIVIDUAL ATTENDANCE POLICY

Welcome to Clinical Services at the Hearing Speech + Deaf Center. We appreciate the confidence you have shown in choosing us as your 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 we may not be able to reschedule another appointment for you within the same week.

2. If you will be late for an appointment, please call to verify your clinician can still see you. If you are 10 minutes late (or more) for an appointment, your appointment may be canceled.

3. It is understandable that, on occasion, you may need to miss an appointment due to illness or a conflict in scheduling. However, it is vitally important that you attend appointments on a consistent basis in order to benefit from the services. Therefore, if you miss more than 1 out of every 4 appointments, your therapy may be discontinued. You may be returned to our waiting list at the discretion of the Director of Clinical Services.

4. A fee of $65 may be assessed for no-show appointments and cancellations of appointments with less than 24 hour notice.

_____ _____

Signature of Patient/Guardian | Printed Name of Patient/Guardian

_____ _____

Signature of Witness | Date/Time

Thank you for taking the time to review our individual attendance policy. Consistent attendance will provide for the best outcomes and improvements.

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CONSENT AND RELEASE FOR INTERVIEW, PHOTOGRAPHING, VIDEOTAPING AND/OR WEBSITE USE

I consent to interview(s), photography, videotaping and its/their release, publication, exhibition or reproduction to be used for public relations, news articles or telecasts, education, advertising, research, inclusion on the HSDC website, fundraising or any other purpose by the Hearing Speech + Deaf Center (HSDC) and/or its affiliates. I release the Hearing Speech + Deaf Center, their Board of Directors and employees and each and all persons involved from any liability connected with the taking, recording or publication of said interviews, photographs, slides, computer images, videotapes or sound recordings.

I waive all rights I may have to any claims for payment or royalties in connection with any exhibition, televising or other publication of these materials, regardless of the purpose or sponsoring of such exhibiting, broadcasting or other publication irrespective of whether a fee for admission is charged. I also waive any right to inspect or approve any photo, video or film taken by HSDC or the person or entity designated by it. I release and discharge HSDC and/or its affiliates(s) from any liability by virtue of blurring, distortion, alteration, optical illusion or use in composite from, whether intentional or otherwise, that may occur or be produced in the taking of the pictures, or in any processing toward the completion of the finished product. All negatives and positives, whether prints, video, film or sound recording, are the property of HSDC or the person or entity designated by it, solely and completely.

I declare that I am eighteen (18) years old or older and I am legally competent to execute this release or that I have acquired the written consent of my parent or guardian. I understand that the terms herein are contractual and not a mere recital, that this instrument is legally binding, and that I have voluntarily signed this document.

☐ **YES,** I consent. I have fully informed myself of this consent, waiver of liability and release before signing it.

☐ **NO,** I do not consent. I have fully informed myself of this consent, waiver of liability and release before signing it.

Signature	Printed Name	Date

☐ I am 18 years or older (if not, parent or guardian must sign below)

I hereby certify that I am the parent or guardian of _____ named above, and do hereby give my consent without reservation to the foregoing on behalf of the person named above.

Parent/Guardian's Signature	Parent/Guardian's Printed Name	Date

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CONSENT AND AGREEMENT FOR CLINICAL OBSERVATION

As a part of Hearing Speech + Deaf Center's efforts to ensure that quality care is provided to all our patients, we encourage student interns to observe sessions by therapists as a part of their internship experience. We also encourage new staff therapists or therapists who are also participating in the care of the patient to observe therapy sessions. Please note that this is observation only and that there will be no videotaping of therapy sessions. The undersigned understands:

1. The patient has a right to refuse to allow other staff to observe sessions at any time.
2. The signing of this form has no impact on the provision of services.
3. The observation will only be done by staff, volunteers and interns for purposes of education, training and quality of service.
4. This consent is voluntary.
5. This consent remains valid unless the patient* or legal representative** withdraws their consent or the client is discharged from services.
6. The observation may be done from the Home Theater (closed circuit television monitor) or within the treatment room with the patient and their therapist.

☐ **Yes,** the undersigned patient* or guardian** consents to and authorizes staff and interns of Hearing Speech + Deaf Center to observe therapy sessions for purposes of education, training and quality of service.

☐ **No,** the undersigned patient* or guardian** does NOT consent to or authorize staff and interns of Hearing Speech + Deaf Center to observe therapy sessions for purposes of education, training and quality of service.

Signature of Client* Date

Signature of Guardian**

Relationship to Patient Date

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CLINICAL SERVICES ADULT CASE HISTORY

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

BACKGROUND

Patient's Name: _____ Preferred Name: _____

Date of Birth: _____ Person Completing Form: _____

Relationship to Patient: _____ Who Lives in the Patient's Home? _____

Primary Concern: _____

Country of Birth: _____ If you were born outside the U.S., when did you come to this country? _____

Primary Language: _____

Other Languages you Use: _____

If English is not your native language, have you had any formal teaching of English? ☐ Y ☐ N

If yes, where? _____

What is your primary mode of communication (speech, sign language, communication device)? _____

Would you like a sign language interpreter for this evaluation? ☐ Y ☐ N

MEDICAL

Do you experience any of the following? (check all that apply)

☐ ADD/ADHD Autism ☐ Chronic Laryngitis ☐ Chronic Respiratory Problems ☐ Chronic Sinus Infection ☐ Dementia

☐ Diabetes ☐ Difficulty Swallowing Food ☐ Dizziness ☐ Heart Disease ☐ High Blood Pressure

☐ History of Dysautonomia/POTS ☐ Seizures ☐ Stroke ☐ Traumatic Brain Injury (TBI) ☐ Visual Problems

Other: _____

Do you have any known allergies? ☐ Y ☐ N If so, list here: _____

Have you been hospitalized? ☐ Y ☐ N Explain: _____

Have you had any surgeries? ☐ Y ☐ N Explain: _____

Do you smoke tobacco? ☐ Y ☐ N If yes, how many packs/day? _____ If yes, for how long? _____

If you quit, how long did you smoke/when did you quit? _____

Have you been diagnosed with or is there a concern about lead poisoning? _____

SOCIAL

Last Grade or Level of Schooling Completed: _____

Occupation (or Former Occupation): _____

Job Description: _____

Employer: _____

Vocational and Other Interests: _____

PREVIOUS EVALUATIONS OR THERAPY

Hearing Evaluation: ☐ Yes ☐ No When: _____ Where: _____

Speech/Language Therapy: ☐ Yes ☐ No When: _____ Where: _____

Vision Test: ☐ Yes ☐ No When: _____ Where: _____

Psychological/Educational Evaluation: ☐ Yes ☐ No When: _____ Where: _____

Physical Therapy: ☐ Yes ☐ No When: _____ Where: _____

Occupational Therapy: ☐ Yes ☐ No When: _____ Where: _____

Counseling: ☐ Yes ☐ No When: _____ Where: _____

Other: ☐ Yes ☐ No When: _____ Where: _____

Please list the names of and any available contact information for any therapists you currently see: _____

_____

HEARING

Do you experience any of the following? (circle all that apply)

Ringing or Buzzing in the Ear(s): ☐ Left ☐ Right ☐ Both ☐ N/A Describe: _____

Is the ringing or buzzing: ☐ Constant ☐ Intermittent ☐ Pulses How long have you noticed it? _____

Are the sounds you hear bothersome? ☐ Yes ☐ No Ear Pain: ☐ Left ☐ Right ☐ Both ☐ N/A

Drainage from the Ear: ☐ Left ☐ Right ☐ Both ☐ N/A Ear Fullness: ☐ Left ☐ Right ☐ Both ☐ N/A

Do you have a history of ear infections? ☐ Yes ☐ No When was your last ear infection? _____

Do you experience the following, and if so, how often?

Dizziness ☐ Yes ☐ No Frequency: _____ Vertigo ☐ Yes ☐ No Frequency: _____

Balance Problems ☐ Yes ☐ No Frequency: _____ Falling ☐ Yes ☐ No Frequency: _____

Can you describe when your dizziness, vertigo or balance problems most often occur? _____

Have you ever had a hearing test? ☐ Yes ☐ No When? _____ Do you have a known hearing loss? ☐ Yes ☐ No

Do you currently wear hearing aids? ☐ Left ☐ Right ☐ Both ☐ N/A How long? _____

Have you ever worn hearing aids in the past? ☐ Left ☐ Right ☐ Both ☐ N/A When? _____

Are your hearing difficulties: ☐ Constant ☐ Fluctuating Did your hearing loss start: ☐ Gradually ☐ Suddenly

Which ear do you think has better hearing? ☐ Left Ear ☐ Right Ear ☐ N/A

When did you first notice your hearing change? _____ Is there a family history of hearing loss? _____

Did any other medical conditions or events occur at the same time you noticed a change in your hearing? _____

_____

Do you have a history of exposure to loud noises/sounds? _____

When do you feel you have the most difficulty hearing or understanding?

☐ Face to Face ☐ In Groups ☐ Hearing the Fire Alarm ☐ On the Telephone

☐ When the Telephone Rings ☐ While Watching TV ☐ Other: _____

SPEECH + LANGUAGE

Do you experience difficulty with any of the following? (check all that apply)

☐ Attention ☐ Comprehension ☐ Memory ☐ Organization ☐ Pronunciation ☐ Stuttering

☐ Time Management ☐ Verbal Expression ☐ Vocal Tone ☐ Word Retrieval ☐ Written Language ☐ Other: _____

Have other people commented on your speech? ☐ Yes ☐ No

Explain: _____

What activities do you enjoy but don't do because of your speech? _____

How do your communication difficulties affect your daily life? _____

Do any family members have speech and language challenges? ☐ Yes ☐ No

Explain: _____

OCCUPATIONAL THERAPY

Do you experience difficulty with any of the following? (check all that apply)

☐ Attention ☐ Dressing Self ☐ Handwriting ☐ Organization ☐ Pain Management

☐ Pill Management ☐ Sensory Aversion ☐ Technology Use ☐ Time Management ☐ Other: _____

What activities do you enjoy but don't do because of these difficulties? _____

How do these difficulties affect your daily life? _____

Do any family members have these challenges? ☐ Yes ☐ No

Explain: _____

CONCLUSION

What questions would you like answered as a result of today's visit? _____

Is there something we haven't asked you that you feel is pertinent to today's visit? _____