HEARING SPEECH + DEAF CENTER

100th ANNIVERSARY

CLINICAL SERVICES ADULT CASE HISTORY

Patient Name		**Race**	**Gender**	**Date of Birth**	**Primary Phone** *PHI may be communicated.
Address	**City**		**State**	**Zip Code**	**Primary Email Address**
Place of Employment, School or Childcare			**Parent/Guardian Name (for minor patients)**		
Preferred Contact Method for Appointment Reminders or Communication: ☐ Phone Call ☐ Text ☐ Email					
Place of Employment, School or Childcare			**Parent/Guardian Name (for minor patients)**		
Primary Doctor's Name			**Office Name**		
Referring Physician (if different from above)			**Office Name**		
Do You Want Reports Sent to: ☐ Primary ☐ Referring ☐ Both ☐ Neither Initial: _____					
Primary Insurance Company			**Policy ID #/Medicaid ID #**		**Group #**
Primary Policyholder Name/DOB			**Secondary Policyholder DOB (if applicable)**		
Secondary Insurance Company			**Policy ID #/Medicaid ID #**		**Group #**

Please provide a list of any/all individuals who may obtain private/protected health information regarding the above patient (e.g., other parent, stepparent, grandparent, health care provider, etc.).

In compliance with the Health Insurance Portability and Accountability Act (HIPAA), protected health information (**PHI**) under the U.S. law is any information about health status, provision of health care or payment for health care created or collected by a Covered Entity and can be linked to a specific individual.

Name of Individual or Entity You Are Authorizing	**Relationship to Patient**	**Phone #**
Emergency Contact		
Other		

How did you hear about us? ☐ Online Search/Web ☐ Newspaper ☐ Social Media ☐ Magazine ☐ Health Fair/Presentation ☐ Physician/School/Childcare Facility ☐ Friend/Family Member ☐ Other: _____

PLEASE INITIAL EACH LINE AND SIGN BELOW

_____ I give my consent for Hearing Speech + Deaf Center to conduct the necessary evaluation, treatments and/or device assistance as I have requested.

_____ I certify that I have read this Center's privacy practices (attached) and that I have had an opportunity to review this document and ask questions. I am satisfied with the explanation and am confident that the facility is committed to protecting my/my child's health information. This acknowledgement will remain in effect indefinitely unless otherwise revoked by a written, dated request. The signature below will remain in effect indefinitely unless terminated by either the patient or Hearing Speech + Deaf Center of Greater Cincinnati.

_____ I have reviewed and agree to the attached financial policy. If you are not the responsible party, provide their name and contact information. _____

Patient/Guardian Signature: _____ Date: _____

Notice of Privacy Practices

Hearing Speech + Deaf Center of Greater Cincinnati is required by law to protect the privacy of your personal health information, provide this notice about information practices and follow the information practices that are described herein.

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 health care 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 HSDC's 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 on page 1, I am consenting to HSDC's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing, to the extent that the practice has already made disclosures based on my prior consent. If I do not sign this consent, or later revoke it, HSDC may decline to provide treatment to me.

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 on page 1, you're 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.

Notice of Privacy Practices

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 or 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, cancel appointments with less than 24 hours' notice or repeatedly no-show for appointments. 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 with HSDC's policies, as stated here.

CLINICAL SERVICES ADULT CASE HISTORY

The clinicians 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 anticipated needs. Please do not leave any part of this form blank.

Name: _____ Date: _____

Do you experience or have you been diagnosed with any of the following: (check all that apply)

- ☐ Autism
- ☐ Chronic Sinus Infections
- ☐ Drainage from the Ear
- ☐ Vertigo/Dizziness
- ☐ Cancer
- ☐ ADHD
- ☐ Ear Infections
- ☐ Ear Fullness
- ☐ Balance Problems
- ☐ Heart Disease
- ☐ Dementia/Alzheimer's/ Memory Loss
- ☐ Ehlers-Danlos Syndrome
- ☐ Family History of Hearing Loss
- ☐ Falling
- ☐ Down Syndrome
- ☐ Diabetes
- ☐ Dysautonomia/POTS
- ☐ Ménière's Disease
- ☐ History of Loud Noise Exposure
- ☐ Usher Syndrome
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Ringing or Buzzing in Ears
- ☐ Ear Pain
- ☐ Acoustic Neuroma

Check answers below:

Do you smoke tobacco? ☐ Yes ☐ No If yes, how many packs per day? _____

If yes, for how long? _____ If you quit smoking, how long ago did you quit? _____

Do you have known allergies? ☐ Yes ☐ No If so, list them here: _____

_____

Do you have a history of surgeries? ☐ Yes ☐ No

If so, list them here: _____

Are your hearing difficulties: ☐ Constant ☐ Fluctuating ☐ Sudden ☐ Gradual

Which ear is better? ☐ Right ☐ Left ☐ About the Same

Do you currently wear hearing aids? ☐ Yes ☐ No ☐ Right Ear ☐ Left Ear

If yes, for how long? _____

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

_____

When do you have the most difficulty hearing and understanding? (check all that apply)

☐ Face to Face ☐ In Groups ☐ Hearing Alarms ☐ On the Telephone ☐ Watching TV ☐ One on One

Other/What question(s) would you like answered as a result of today's visit? _____

_____

_____

_____

_____

_____

Are you interested in our speech therapy or occupational therapy services? If yes, check which service below:

☐ Speech Therapy ☐ Occupational Therapy