

## COLUMBUS SPEECH & HEARING CENTER

### Adult Audiology History

*Our concern is your hearing. To better help you, we ask that you fill out this questionnaire to describe in what ways your hearing affects you. This information is kept confidential and is made a part of your permanent file. Thank you for placing your trust in us for all your hearing needs. Please complete this form and return it to the front desk.*

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 How did you hear about us? \_\_\_\_\_ Name of spouse or friend with you today? \_\_\_\_\_  
 Referral source: \_\_\_\_\_ To whom should reports go: \_\_\_\_\_

Check any of the following that you currently have, or have had:			
High blood pressure	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Mumps	<input type="checkbox"/>
Meningitis	<input type="checkbox"/>	General anesthetic	<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

1. List any chronic illnesses: \_\_\_\_\_
2. List all current medications: \_\_\_\_\_
3. How is your current health? \_\_\_\_\_
4. Was the onset of your hearing loss sudden or gradual? \_\_\_\_\_
5. Who first noticed your hearing problem? \_\_\_\_\_ When? \_\_\_\_\_
6. Describe any medical treatment you may have had for your hearing problem: \_\_\_\_\_

6. In which ear do you hear better?                      Left                      Right

7. If you have tinnitus (ringing, buzzing, hissing) sounds in your ear:
- a. in which ear does it occur?    Left            Right            Both
  - b. when did you first notice it? \_\_\_\_\_
  - c. What is the frequency?            Constant            Occasional

8. When was the last time you had your hearing tested? \_\_\_\_\_ Where? \_\_\_\_\_

9. Why have you decided to have your hearing tested at this time?
- a. I feel my hearing is poor and may need to be aided
- b. Family/friends have suggested I have my hearing tested.
- c. Other/explain: \_\_\_\_\_

10. If you wear hearing aids:
- a. In which ear? Circle:                      left only                      right only                      both ears
  - b. When did you buy your hearing aids? \_\_\_\_\_
  - c. Approximately how many hours a day do you wear them? \_\_\_\_\_
  - d. Do you have any problems with your aids? \_\_\_\_\_ If Yes, explain: \_\_\_\_\_

Yes	No	<i>For "Yes" answers to the following questions, please explain</i>
<input type="checkbox"/>	<input type="checkbox"/>	Have you been exposed to loud noise for long periods of time?
<input type="checkbox"/>	<input type="checkbox"/>	Does anyone in your family have hearing loss?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have dizziness, vertigo or loss of balance?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever worn a hearing aid?
<input type="checkbox"/>	<input type="checkbox"/>	Did you have chronic ear infections as a child or adult?
<input type="checkbox"/>	<input type="checkbox"/>	Do your ear canals itch? _____ Do you have tubes or holes in your eardrum? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have sinus or allergy problems? _____ Pain or discomfort in your ears? _____
Do you have difficulty when:		
<input type="checkbox"/>	<input type="checkbox"/>	a. someone speaks in a whisper?
<input type="checkbox"/>	<input type="checkbox"/>	b. Visiting friends, relatives or neighbors?
<input type="checkbox"/>	<input type="checkbox"/>	c. Listening to TV or radio?
<input type="checkbox"/>	<input type="checkbox"/>	d. Listening to children or women?

## WELCOME TO OUR PRACTICE

Welcome to our practice at Columbus Speech & Hearing Center! Your presence here means that you have taken the first step in changing a speech and/or language problem, something that affects 10% of our population. It will be our honor to help you meet your therapy goals in the shortest time possible. Our therapy journey will be one of cooperation, open communication, and mutual respect. We want your attendance here to be pleasant as well as beneficial to you or your family member's speech-language development. To help in that process, provided below is basic information related to therapy, billing, attendance, communication with staff, etc. If you have questions not answered below, do not hesitate to call or ask our staff.

**Services offered in the clinic:** Three basic types of services are offered:

- **Speech-language therapy** for young children through geriatrics. Our youngest patients are premature babies who were tube fed and later needed help learning to suck-swallow-breathe; our oldest are often stroke patients. They come from all walks of life, all socio-economic stratas, a range of occupations. Specialty programs include swallowing, reading, cognitive rehabilitation for memory loss, voice, and pediatric language development. Our staff provides services at The Medical Center, Doctors Hospital, Hughston Hospital, two nursing homes, Head Start, Brookstone School, and in this clinic.



- **Audiology services.** We have the only regional department staff whose diagnostic services are provided solely by doctoral level audiologists. They offer a complete range of hearing evaluations, assessment of dizzy/balance disorders, hearing aid sales and maintenance. They test the hearing of all newborn babies at Doctors Hospital and babies in the High Risk Nursery at the Medical Center. They provide complete hearing evaluations and dizzy/balance assessments for numerous local physicians in private practice, and for those at Martin Army Community Hospital. They are the Preferred Providers by the City of Columbus, for their employees.



- **Psychological services.** These services begin in January, 2010, provided by Dr. Rabia Subhani-Siddique. Dr. Siddique is licensed clinical psychologist specializing in pediatric neuropsychology. She is trained in ADOS (the gold standard for Autism Spectrum Disorders) and was triage coordinator at Emory's Autism Research Center. Services include evaluation and treatment for neurodevelopmental disorders (Autism, developmental delays), neuropsychological (attention, learning, memory), psycho-educational (skills needed for academic success and placement) and general psychological (cognitive functioning, personality, emotional functioning and adaptive skills).

***Factors affecting extent of progress and rate of progress for different speech-language disorders:***

A number of things are important, including the disorder itself – those with a neurological or physical cause are often more difficult to correct than developmental disorders. The more severe the disorder, the longer it takes to correct. A very important variable is the consistency and thoroughness with which home work is completed. Children cannot complete it alone, so parents must help, which means the parents must observe therapy on a regular basis to learn how to reinforce emerging new speech and language patterns at home. Parental observation of therapy is encouraged and welcomed! We need your help. The child needs your help. It makes the difference in a child's getting a few hours of therapy a month directly from the therapist, versus that same therapy contact supplemented by daily, almost hourly, reinforcement from parents in the child's home environment. Another crucial factor affecting progress is regular attendance. Therapy is planned in a sequential manner with predictable time frames between steps. If attendance is not regular, progress will be hindered and enthusiasm for the process may be affected. (See separate attendance policy).

***Contact information for staff:*** For all departments, call our main number (706-324-6112). If the therapist is not available, you will be routed to his/her voice mail, which is checked several times a day. It may be late in the afternoon before you get a return call, but it will be returned. If you need a faster response, tell the receptionist and she will get your message to the therapist between patients. Also, do not hesitate to ask for your therapist's email address. That can be an effective way to avoid playing phone tag. Other numbers include:

- **Billing:** Brandon Glover, Office Manager. 706-324-6112, extension 217.
- **Scheduling:**
  - **Amy Goodrich:** Clinic Coordinator. Ext.220
  - **Sheri Love:** Audiology Receptionist. Ext. 201
  - **Veta Haltrich:** Adult Receptionist, schedules adult speech patients for Dr. Ford, Dizzy/balance evaluations for Dr. Cellino and NeuroPsych evaluations for Dr. Subhani-Siddique. Ext.204
  - **Heather Martin:** Pediatric Receptionist. Ext. 202
  - **Martha West:** Insurance Questions. Ext. 216
  - **Ashley McMahan:** Medical Records. Ext. 203

***Insurance coverage:*** CSHC is an approved provider for major insurance companies including Medicare, Medicaid, Tricare, and most private companies, with the exception of United Healthcare. Upon request, our front office staff calls for prior authorization of therapy before services begin. This helps rule out some disorders not covered. In some cases, coverage is not clear ahead of time. The carrier may refuse to commit to coverage until after treatment is provided. In all cases, the patient is ultimately responsible for payment of services either not covered at all by insurance, or for their share of the cost when insurance is a partial payor. The patient share is expected at the time services are rendered.

**Hours of operation:** 8:00 AM – 5:00 PM, Monday through Friday. Someone is usually here by 7:45 AM to take early calls. Most therapy is between 8:00 AM – 5:00 PM.

**Holidays:** News Years Day, Memorial Day, 4<sup>th</sup> of July, Labor Day, Thanksgiving, Christmas Eve, and Christmas Day. Reminders are posted a week before each holiday.



## PATIENT INTAKE INFORMATION

PATIENT	FILE:	SOC SEC #	SEX: M    F	MARITAL STATUS	BIRTHDATE	PHYSICIAN	OCCUPATION	
	LAST NAME		FIRST NAME		MI	EMPLOYER		
	IF PATIENT IS A MINOR:						EMPLOYER ADDRESS	
	Father's name:		Social security number		Address if different from below		WORK PHONE	
	Mother's name:		Social security number		Address if different from below		HOME PHONE	
	STREET ADDRESS						CELL PHONE	
	CITY		STATE		ZIP CODE		EMAIL	
REFERRAL SOURCE								

RELATIVE	LAST NAME		FIRST NAME		MI	RELATION TO PT:	
	STREET ADDRESS		CITY		STATE	ZIP CODE	PHONE:

INSURANCE IDENTIFYING INFORMATION	PRIMARY INSURANCE		SECONDARY INSURANCE	
	NAME OF INSURED			
	POLICY NUMBER			
	GROUP NUMBER			
	EFFECIVE DATE			
	PAYER ID			
	CONTRACTED PLAN YEAR			
	TYE PLAN: HMO, POS, PPO, INDEMNITY			
	IS CSHC IN NETWORK OR OUT OF NETWORK?			
DOES THE PATIENT RECEIVE ANY HOME HEALTH, HOSPICE OR SKILLED NURSING CARE?		YES	NO	
DOES THE PATIENT RECEIVE SPEECH SERVICES AT ANY OTHER FACILITY?		YES	NO	

PATIENT VERIFICATION OF ACCURATE INSURANCE INFORMATION AND RESPONSIBILITY FOR PAYMENT	
<p>I understand and agree that I am ultimately responsible for payment in full for any professional services rendered, regardless of my insurance status. I have read the information on this page and certify the information to be true and correct to the best of my knowledge. I understand that all claims are subject to individual contract policy and to medical necessity review. Prior authorization for a procedure is not a guarantee of payment. I will promptly notify you of any changes in my health status or the above information.</p>	
Patient signature/ or Parent if patient is a minor	Date

## SIGNATURE PAGE

**Instructions:** Please initial beside each of the following items, indicating your authorization or agreement.

Date	Yes, I agree	No, I do not agree	
			<b>CONSENT FOR TREATMENT</b> I hereby consent to such diagnostic procedures, and medical treatment, which in the judgment of my Physicians may be considered necessary or advisable while a patient at Columbus Speech and Hearing Center
			<b>ASSIGNMENT OF BENEFITS:</b> I hereby authorize payment directly to Columbus Speech & Hearing Center of the Medical Benefits, otherwise payable to me for services described above, but not to exceed reasonable and customary charges for those services. I understand and acknowledge that this assignment does not relieve me of my financial responsibility. If payment has not been received from the insurance carrier, <i>I accept personal liability for the charges not reimbursed by Insurance within 45 days.</i>
			<b>AUTHORIZATION TO RELEASE INFORMATION:</b> I consent to the release of relevant diagnostic, therapy, or other related materials to qualified professional personnel in furtherance of clinical services on behalf of me or my minor being seen; or for whom I am legally responsible, as deemed medically necessary by the attending Speech-Language Pathologist and/or Audiologist at Columbus Speech and Hearing Center.
			<b>ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES</b> (you may refuse to sign this acknowledgement) I have received a copy of this office's <i>Notice of Privacy Practices</i> .

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

### MEDICARE OR MEDICAID AS SECONDARY INSURANCE

I am aware that I am personally responsible for any and all Medicare co-pays, co-insurance, and deductibles for Speech and/or Hearing evaluations or therapy. I am aware that Columbus Speech and Hearing Center cannot bill Medicaid for services rendered on patients over 21 years of age. I agree to pay all monies due to Columbus Speech and Hearing Center at the time services are rendered or upon receipt of an invoice for services rendered by Columbus Speech and Hearing Center.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature/Date

\_\_\_\_\_  
Witness

### FOR OFFICE USE ONLY

We have attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices*, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)