

YOUR CHILD'S HEARING HISTORY

Name _____ Birthdate _____ Today's Date: _____

How did you hear about us? _____ To whom should reports go: _____

Reason for current visit

What is the purpose of today's visit? (What are your concerns?) _____

Identify concerns of teachers, or family members, about your child's hearing: _____

Yes	No	Specific questions about your child's hearing history
<input type="checkbox"/>	<input type="checkbox"/>	1. Does your child respond to sound consistently?
<input type="checkbox"/>	<input type="checkbox"/>	2. Do you repeat often for your child to understand?
<input type="checkbox"/>	<input type="checkbox"/>	3. Does your child like to sit close to the TV or does he/she turn up the volume?
<input type="checkbox"/>	<input type="checkbox"/>	4. Has your child had a formal hearing test by an audiologist? When & where?
<input type="checkbox"/>	<input type="checkbox"/>	5. Does anyone in your family have a hearing loss?

Specific questions about your child's ear history

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Has your child had ear infections? If yes: |
| <input type="checkbox"/> | <input type="checkbox"/> | a. Did they occur in the first 18 months of life? How many? _____ |
| | | b. At what age did the first ear infection occur? _____ How many since then? _____ |
| | | c. When did the last ear infection occur? _____ |
| | | d. How long does it take for an ear infection to clear? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Is your child currently taking antibiotics for an ear infection? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Has your doctor ever reported fluid behind your child's eardrum? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Has your child complained of pain, discomfort, or ringing in the ears? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Has your child had any balance, nausea or dizziness problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Has your child ever been seen by an ENT physician? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Has your child ever had pressure equalizing tubes for chronic ear infections? |
| | | How many sets of tubes? _____ At what ages? _____ |

Hearing aid history: if your child has ever worn a hearing aid, please answer the following

1. Does your child wear one now? What make and model _____
2. When did your child first start wearing a hearing aid? _____
3. When did you purchase the present hearing aids? _____
4. Have the aids been satisfactory or unsatisfactory and why? _____
5. How many hours a day are they worn? _____
6. How often do you replace the batteries? _____

Social/developmental History

1. How well does your child interact with others his/her own age? _____
2. Describe progress in school _____
3. At what age did your child Walk? _____ Say his first word? _____ phrases? _____

Specific questions about your child's general health & medical history

Check any of the following that your child currently has or has had:

Frequent colds	Head trauma	Holes in eardrums
High fevers/serious illness	Difficulty breathing	Transfusions
Seizures/convulsions	Birth complications	Jaundice

1. List any chronic illnesses: _____
2. List all current medications: _____
3. List any surgeries: _____
4. Describe any problems with your pregnancy or delivery with this child: _____
5. Circle any of the following that apply to your pregnancy: premature delivery Rh factor
TORCH infection Birth complications Illness during pregnancy
6. What was the baby's birth weight? _____ APGAR at 1 minute? _____ at 5 minutes? _____

Thank you for helping us help you hear better! Please return this form to the front desk.

WELCOME TO OUR PRACTICE

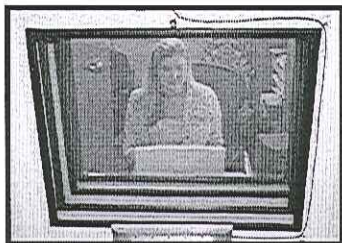
Welcome to our practice at Columbus Speech & Hearing Center! Your presence here means that you have taken the first step in changing a speech and/or language problem, something that affects 10% of our population. It will be our honor to help you meet your therapy goals in the shortest time possible. 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, 4th 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			
	EFFECTIVE DATE			
	PAYER ID			
	CONTRACTED PLAN YEAR			
	TYPE 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	CONSENT FOR TREATMENT
			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
			ASSIGNMENT OF BENEFITS: 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>
			AUTHORIZATION TO RELEASE INFORMATION: 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.
			ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (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)