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 _____ Referring Doctor _____

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 screening/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 screenings, 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 audiologist/speech pathologist/occupational therapist about the purpose, potential risks and benefits of any treatment ordered for you. If you have any concerns regarding any treatment recommended by your provider, we encourage you to ask questions.

I voluntarily request a 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) |
|---|---|---|---|
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HEARING SPEECH + DEAF CENTER

# Adult Hearing Health History

Patient's Name _____ Date _____

## General Hearing Information

What is your primary reason for your visit today? _____

Do you smoke tobacco Y N If Yes # packs/day_____

If Yes for how long_____ If quit, how long did you smoke/when did you quit_____

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

Ringing or Buzzing in the ear(s) Left Right Both Describe_____

Is the ringing or buzzing: Constant Intermittent Pulses How long have you noticed it_____

Are the sounds that you hear bothersome Y N Ear Pain Left Right Both

Drainage from the Ear Left Right Both Ear Fullness Left Right Both

Do you have a history of ear infections Y N When was your last infection_____

Do you experience the following and if so how often

Dizziness Y N Frequency_____ Vertigo Y N Frequency_____

Balance problems Y N Frequency_____ Falling Y N Frequency_____

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

Have you ever had a hearing test Y N When_____ Do you have a known hearing loss Y N

Do you currently wear hearing aids R L B How Long_____

Have you ever worn hearing aids in the past R L B When_____

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

Which ear do you think has better hearing? Right ear Left Ear

Any operations involving the ear/head_____

Any injuries involving your head_____

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_____

Where do you feel you have the most difficulty hearing or understanding_____

What questions would you like answered as a result of today's visit_____

Communication Problems (Circle situations where you have difficulty hearing) Face-to Face In Groups Hearing the fire alarm

On the Telephone When the Telephone Rings While Watching TV

Give examples of places you want to hear better_____

Is there something that we haven't asked you that you feel is pertinent to today's hearing test_____

Please list any disease, illness, syndrome or disorder that you have been diagnosed with_____

_____