Heuser Hearing Institute

Pediatric Speech Case History

Name: _____ Date: _____

DOB: _____ Gender: M_____F _____

Person Completing Form: _____ Relationship: _____

Mother: _____ Father: _____

Reason for visit or concern: _____

Patient Address: _____

Patient Phone number: _____

Patient Email Address: _____

Pediatrician: _____Phone Number: _____

ENT Physician: _____ Phone Number: _____

Has your child been seen by other medical professionals about your concern? If yes, please list.

Professional: _____ Phone: _____Date:_____

Professional: _____ Phone: _____Date:_____

Do you or your child have special needs or require assistance to help us prepare for this evaluation? If yes, please explain: _____

Medical and Developmental History:

Birth Hospital: _____

Length of Term: _____ Child's Birth Weight: _____

Has your child had a history of any of the following conditions?

Intubation/ventilation	Hospitalization/Surgeries	Chronic/severe illness
Head injury	Excessive drooling	Allergies/Asthma
Ear infections	Ear tubes (include date)	Tongue Tie

Explain any circled areas: _____

Describe any difficulties that you or your child experienced during labor or delivery:

_____

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Does your child take any medications? Yes ___ No ___

If yes, explain: _____

Did your child meet developmental milestones appropriately (sitting, crawling, walking, etc.)?

Yes ___ No ___ If no, please explain: _____

Has your child ever been evaluated by any other professional (OT, PT, DI)? Yes ___ No ___

If yes, please explain: _____

Has/is your child enrolled in First Steps or other therapy services? Yes ___ No ___

If yes, explain: _____

Auditory Development:

Did your child pass their Universal Newborn Hearing Screening? Yes ___ No ___

Are you aware of any conditions that would make your child "at risk" for hearing difficulties?

_____

Is there a family history of hearing loss? Yes ___ No ___

If yes, explain: _____

Does your child have a hearing loss? Yes ___ No ___

If yes, please explain (type/degree/side): _____

Do you suspect your child has a hearing loss? Yes___ No___ **(if no, please continue to next section)**

When was your child's hearing last evaluated? _____

Does your child wear hearing aids or have a cochlear implant? HA ___ CI ___ Make_____

Model: _____ Ear(s) aided: **RIGHT** **LEFT** **BOTH** Date of first fitting: _____

On average, how many hours a day does your child wear their amplification? _____

Speech and Language Development:

What is your primary speech and/or language concern? Please circle all that apply:

Articulation	Receptive Language	Expressive Language
Stuttering	Listening/Processing	Academic/Reading

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Is there a family history of speech, language, and/or learning difficulties? Yes ___ No ___

If yes, please explain: _____

Did your child babble? If yes, did they make a variety of sounds? Yes ___ No ___

If no, please explain: _____

At what age was your child's first word? Please list a few examples: _____

At what age did your child begin to put words together? _____

How does your child typically communicate his/her wants or needs? _____

_____

What percent of the time do you feel you understand your child? _____

What percent of the time do you feel unfamiliar people understand your child? _____

Has your child ever been evaluated and/or received speech-language therapy before?

Yes ___ No ___ If yes, when/where/why _____

_____

Were you satisfied with the progress your child made in therapy? Yes ___ No ___

If no, please explain: _____

_____

Academic Development:

Is your child currently enrolled in school? Yes ___ No ___ N/A___

If yes, what grade: _____ where: _____

If no, please explain: _____

Do you have any academic concerns (reading, phonological awareness, paying attention, etc.)?

Yes ___ No ___ If yes, please explain: _____

_____

Does your child currently have an IEP or 504 Plan? Yes ___ No ___

If yes, please list "Primary Disability" and current accommodations: _____

_____

Does your child receive any services at school? If so, please explain: _____

Heuser Hearing Institute

Speech Services Policies and Procedures

Thank you for choosing the Heuser Hearing Institute (HHI). Below are several policies as they relate to speech-language evaluations and therapy. By signing below, you are accepting the terms of these policies.

Benefits Check

Prior to scheduling, the patient is responsible for contacting the billing department to discuss payment options. HHI accepts most insurance carriers and is happy to run your benefits information as it pertains to speech-language therapy. Insurance billing rates will apply to all services rendered. Payment coverage is plan specific. This includes, but is not limited to: rates, deductibles, setting requirements, number of visits, etc. The family is responsible for knowledge of insurance benefit information.

Insurance Billing

If the family chooses to bill insurance, the family is acknowledging:

- That Heuser Hearing Institute can release personal healthcare information, which is necessary in order to process my insurance claim.
- That the family is financially responsible to Heuser Hearing Institute for any charges incurred for services performed regardless of insurance coverage.
- That it is the family's responsibility to be informed regarding insurance coverage and provide Heuser Hearing Institute with current insurance information should there be any change in coverage. The clinician is not responsible for managing insurance information and/or payment concerns. **The Heuser Hearing Institute Billing Office can be reached at: 502-371-9910**
- If the insurance company requires a referral, it is the family's responsibility to obtain any required referrals prior to the date of the evaluation. Failure to do so may result in denial of the claim by insurance.

Self-Pay

HHI also accepts self-pay for both the evaluation and therapy services. The rates are subject to change. Families will be notified in writing when changes occur. **All rates effective January 1, 2019.**

Evaluation

The rates for evaluations are listed below:

- Speech and Language Evaluation $ 240.00
- Speech Only Evaluation $ 121.00
- Fluency Evaluation $ 148.00

- Annual Re-Evaluation Speech Only $ 65.00
- Annual Re-Evaluation Speech and Language $120.00

Therapy

The rates for speech therapy are listed below:

- 30 minute speech therapy session is $50.00
- 60 minute speech therapy session is $95.00

Heuser Hearing Institute

Payment Authorization

Heuser Hearing Institute can accept the following forms of payment.

- Exact cash **at clinic only**
- Personal check at time of service **at clinic only**
- Credit card
- Health Savings Account/Flexible Spending Account

Families may choose to have payments collected on the date of service or the first business day of each month for services rendered the previous month (credit card must be on file). In order to use a credit card or HSA/FSA the following information must be submitted:

Name on Card: _____ Card Type: _____

Card Number: _____

Expiration Date: _____ Security Code (CVC):_____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Please Note: We cannot file with your HSA/FSA if you are paying privately and your insurance provider requires a "Denial Explanation of Benefits (EOB)". You are responsible for determining if your insurance provider requires this information.

Additionally, a re-evaluation will be completed annually through your insurance or paid privately at the rates listed above. In order to proceed with scheduling, the patient must indicate **one** payment method below.

I have read, understand, and agree with the above policies. I have spoken with the Heuser Hearing Institute's Billing Department and my insurance company. I have completed the attached billing information sheet. I am aware of and acknowledge my insurance coverage as it relates to speech – language services.

☐ **I am choosing to bill my insurance.**

☐ **I am choosing to pay privately at the agreed upon rates listed above.**

Scheduling

Upon completion of the speech-language evaluation, the speech-language pathologist will discuss the length and frequency of sessions. Every effort will be made to accommodate a time and day that is convenient for the client. In the case that all therapist schedules are full, a waitlist will be implemented.

Please note for all clients seeking an after-school time, all sessions will be completed by 6:00 pm.

Heuser Hearing Institute

Attendance Policy

Regular attendance and punctuality are essential to the progress a person will be make in therapy. The Heuser Hearing Institute understands that unforeseen circumstances cannot always be avoided. Therefore the following guidelines were established:

- If planning to be absent to an evaluation or therapy appointment, please notify the provider prior to the appointment time.
- If client "**no shows**" with no attempt of notification more than **3** times, the client will be removed from the provider's schedule.
- "No show" refers to an absence in which the provider was not notified prior to the appointment time.
- Patients are expected to **attend 80%** of all scheduled sessions in order for patients to make consistent progress.
- Providers can be reached at 502-371-9935 (downtown), 502-371-9912 (Lyndon) or via their personal cell phone (voice call or text).
- Providers will also adhere to attendance policy, therefore if clinician is planning to be absent, parent will be notified prior to the appointment time.
- Clinician must be notified, if planning to be late and session **will not** extend past scheduled time.
- If family arrives 15 minutes past the scheduled appointment time, session will count as a **"no show"** and the child will not be seen.

Family Participation and Patient Progress

Regular attendance and punctuality are essential to the progress a person will be make in therapy. Family participation contributes to patient carry-over and prognosis for discharge. Due to liability purposes, parents **must** be on campus for the **duration** of the scheduled therapy session. Minors cannot be left without a guardian in the building. Sessions will include time at the end to discuss patient progress and recommended home practice. All services will be completed within designated time slot unless otherwise discussed prior to the session.

Parental Consent, Release and Wavier of Liability

I consent to the minor's participation in speech – language therapy at the Heuser Hearing Institute and herby accept and assume all such risks, known and unknown, and assume responsibility for the losses, costs and/or damages following injury disability, paralysis or death, even if caused in whole or in part, by the negligence of the releases named below.

I have read, understand, and agree with the above policies.

_____ _____

Signature (Parent/Legal Guardian) Date

I was given a copy of this signed agreement:

Heuser Hearing Institute

_____ _____

Signature (Parent/Legal Guardian) Date

Authorization for Release of Protected Health Information

Patient Name: _____ DOB: ____/_____/_____

I hereby authorize the Heuser Hearing Services Center to
_____Release To or _____ Release From
(Please Check One)

Please list below person or entity records are to be disclosed

_____
_____
_____
_____

If you would like us to share your medical information with the University of Louisville researchers please check here:
YES_____ NO_____

I authorize the following protected health information to be released: (Specific description of portions of records to be released, i.e. clinic dictation, hearing testing, vestibular testing, diagnostic testing, educational information, psychological information, social/development, treatment plans, therapy notes, etc. and time periods of information to be released.

_____
_____
_____
_____

This authorization for use/ disclosure is for the following purpose:

_____
_____

I understand that the medical record release pursuant to this authorization could contain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious disease, which are subject to federal and/or state restrictions on disclosure. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

I understand that I do not have to sign this authorization and that the Heuser Hearing Services Center may not condition treatment or payment on whether I sign this authorization. However, I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter to Heuser Hearing Services Center at the address listed in this authorization form. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

Unless otherwise revoked, I understand that authorization will expire one hundred and eighty (180) days from the date of this form or on the following date event:

_____

_____ _____

Signature of Patient/ Legal Guardian Date

Heuser Hearing Institute

_____	_____
Printed Name of Patient Representative given authority to act for patient	Relationship to patient

Heuser Hearing Institute
INSURANCE BILLING INFORMATION

Patient's Full Name: _____ Date of Birth_____

Patient's Address: _____Home Phone _____

City: _____ State: _____Zip: _____

Alternate Phone: _____ Social Security No: _____

Referring Physician: First Name: _____ Last Name: _____

Address/Phone:_____

Primary Care Physician: First Name: _____ Last Name: _____

Address/Phone:_____

Emergency Contact: _____ Phone: _____

E-Mail Address:_____

☐ **YES** – I would like to be kept up-to-date on hearing devices, technology, and happenings around our office and campus.

☐ **YES** – I would like to receive the "Good Vibrations" newsletter.

BELOW INFORMATION IS NEEDED TO FILE INSURANCE

Responsible Party or Father's Name: _____Responsible Party or Mother's Name_____

Employer: _____ Work Phone: _____ Employer: _____ Work Phone: _____

Primary Insurance:_____ Group No.:_____

Subscriber's Name:_____ I.D. No.:_____

Date of Birth: _____

Secondary Insurance:_____ Group No.: _____

Subscriber's Name: _____ I.D. No.: _____

Date of Birth: _____

Please check any of the following methods that apply to your coverage:

_____ Self Pay _____ Insurance filed by patient
_____ Disability Determinations
_____ Insurance filed by Heuser Hearing Institute
_____ Referred by Vocational Rehabilitation
_____ Other (Please explain)

_____

I hereby authorize the release of medical information or other information acquired during the course of examination and treatment to insurance carriers, physicians, or my legal representatives. I hereby request payment of benefits from all insurance carriers to The Heuser Hearing Institute. I understand I am responsible for and will pay any amount not covered by insurance including collection costs and reasonable attorney fees if referred for collection. I understand that I am responsible for all referrals to be sent to Heuser Hearing Institute prior to any services being rendered. I understand that as Medicaid recipient and over the age of 21 years, I am fully responsible for my bill.

SIGNATURE _____ DATE _____

Heuser Hearing Institute

Patient Name:_____

NOTICE OF PRIVACY PRACTICES (Effective April 14, 2003)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The federal law called the Health Insurance Portability and Accountability Act of 1993 ("HIPPA") creates certain rights for our patients. One of those is a right to information regarding our privacy practice. Under federal regulations, we must provide you with a copy of this Notice of Privacy Practices and ask that you sign an acknowledgement that we gave the notice to you. You may review the Notice of Privacy Practices immediately or later. At some point, you should read it carefully because it explains:

- Generally how we use health information about you;
- That we, like other health care providers, may use and disclose health information about you as part of your treatment, to arrange for payment for services provided and for our internal operations. We are not required to have separate permission for these uses and disclosures;
- Other circumstances where we may use or disclose information about your health where we are not required to get your permission first;
- The rights you have with respect to health information we have about you, including
  - Your right to have a copy af this privacy notice;
  - Your right to review and copy health information that we may have about you;
  - Your right to an accounting for how we use and disclose your health information, other than for treatment, payment or health care operations;
  - Your right to request that we communicate with you at alternative locations, mailing addresses or telephone numbers.
  - Your right to request restrictions on how we use your health care information;
  - Your right to request and amendment to information in our records that you think is an error; and
  - Your right to file a complaint if you think your privacy rights have been violated.

Acknowledgement of Receipt: I acknowledge receiving a copy of the Notice of Privacy Practices for **The Heuser Hearing Institute and The Heuser Hearing and Language Academy** this _____day of _____, 201__.

Signature: _____

Please Print Name: _____
(If not the patient)
If you are not the patient, state your relationship: _____

Heuser Hearing Institute

Heuser Hearing & Language Academy

formerly Louisville Deaf Oral School

PERMISSION TO EVALUATE AND TREAT

I, _____, give my permission for my child,
(name of legal guardian)

_____, to be evaluated for _____
(child's name) (type of evaluation)

(and to receive treatment if necessary), by _____.
(name of evaluator)

I understand the all evaluation results will be shared with me.

_____ _____
Parent/Legal Guardian Date