



Thank you for making your appointment with The Speech & Hearing Center on _____
at _____

Enclosed in this package in an Intake Form, Consent to Comply with Federal HIPPA Act, Case History, Consent to Exchange Information, and directions to our location.

Please complete the enclosed forms and return to our office with a copy of your insurance card, prior to your appointment. This will let us get you in to see the doctor sooner on the day of your appointment.

The completed forms can be returned to our office by fax at (423) 622-4834, by mail at 6016 Shallowford Road, Suite 1500, Chattanooga, TN 37421, or they can be delivered to the office in person.

Please arrive **15 minutes** prior to your scheduled appointment time to allow extra time for intake before seeing the Speech-Language Pathologist.

If you have questions before your appointment, please give us a call at 423-622-6900.

Thank you,

The Speech & Hearing Center

6016 Shallowford Road, Suite 1500 · Chattanooga, TN 37421

433 North Ocoee Street, Cleveland, TN 37311

Phone: 423.622.6900

Fax: 423.622.4834

www.speechhearing.com



6016 Shallowford Road
Suite 1500
Chattanooga, TN 37421
Phone: 423.622.6900
Fax: 423.622.4834

Patient Information

Patient's Name _____
First Initial Last

Responsible Party (If patient is a child, Parent or Guardian): _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Social Security # _____ DOB: _____ Sex: M or F (circle) E-mail: _____

Marital Status: Married Single Other Employment Status: FullTime PartTime None Student Status: FullTime PartTime None
circle circle circle

Referring Physician: _____

Primary Physician: _____

Is there a place/physician we can send a copy of your test results? _____

Emergency Contact: _____ How did you hear about us? _____

Primary Insurance Information (if patient is also the Insured, enter 'SAME' for name & address) Office: Insurance on File?

Insured's Name _____
First Initial Last

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Patient Relation to Insured Self Spouse Child Other Insured Date of Birth _____ Insured Sex M F (circle)

Insured Employment Status Full-Time Part-Time None Insured Employer _____
(circle)

Insurance Co. Name _____ Subscriber ID Num _____ Group Num: _____

Other Insurance Information (If patient is also the Insured, enter 'SAME' for name & address)

(Office only): Insurance Card copy on file? _____

Insured's Name _____
First Initial Last

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Patient Relation to Insured Self Spouse Child Other Insured Date of Birth _____ Insured Sex M F (circle)

Insured Employment Status FullTime PartTime None Insured Employer _____
(circle)

(circle)

Insurance Co. Name _____ Subscriber ID _____ Group Num _____
Num _____

I authorize any holder of medical or other information about me to release any information needed to process this or other claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Signed _____ Date _____



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ADULT HEARING CASE HISTORY- CONFIDENTIAL INFORMATION

Please Answer Questions on the Front and Back of this Form

Name _____ Date of Birth _____

Who referred you to The Speech and Hearing Center? _____

Reason for Referral? _____

Name of Primary Care Physician: _____

Please answer the following questions about your hearing:

	YES	NO
Do you have a hearing problem?	<input type="radio"/>	<input type="radio"/>

What do you think caused your hearing problem? _____

How long have you had this difficulty? _____

Has it changed recently?	<input type="radio"/>	<input type="radio"/>
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Please explain: _____

Have you ever had ear surgery?	<input type="radio"/>	<input type="radio"/>
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Please explain: _____

Which ear is better? (Please circle) Right Left Same

Do you have discomfort (pain or pressure) in your ears?	<input type="radio"/>	<input type="radio"/>
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Please explain: _____

Are you having any dizziness or balance problems?	<input type="radio"/>	<input type="radio"/>
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Please explain: _____

Do you have ringing in your ears or other head noises?	<input type="radio"/>	<input type="radio"/>
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Right Left Constant Frequent Occasional

Please rate the loudness of the noise or ringing: Mild ___ Moderate ___ Severe ___

Please describe the sound you hear in your head or ear: (ie. ringing, buzzing, frying, roaring, voices)

Have you been exposed to loud sounds? 0 0
(examples: guns, saws, loud machines, loud music)

Please Describe: _____

Do any of your family members have a hearing problem? 0 0

If yes, please state relationship and explain: _____

Have you ever worn a hearing aid? 0 0

If so, how many years? _____

Are you wearing a hearing aid(s) now? 0 0

Right Left

Where do you have difficulty hearing? (ie. Restaurants, Church Family gatherings, TV, Telephone)

Describe any additional physical or medical problems:

List any medications you are currently taking: _____

Are you interested in wearing hearing aids? _____

Signature of the person completing this form: _____

Relationship to patient: _____ : _____

Date: _____



THE
SPEECH & HEARING
CENTER

Enhancing Communication. Enriching Lives.

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PH :423.622.6900 FX: 423.622.4834
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CONSENT TO EXCHANGE INFORMATION

Patient's Name: _____ Date of Birth: _____

Current Address: _____

Telephone Number(s): _____

I hereby give my consent for the Speech and Hearing Center to exchange information with:

(Name and Address of Agency/Individual; for example: Referring Physician, Family Member, Spouse or other Guardian, Educator or Agency)

Information exchanged may include but is not limited to speech/language and hearing records, medical reports, academic information and program planning. Information may be shared through written reports, by phone, fax or in person.

All of the information I hereby authorize to be exchanged with the above will be held strictly confidential and cannot be released without my written consent. I understand that I have the right to inspect and copy the information to be disclosed. I understand that I may withdraw this authorization at any time.

This request is effective up to and including one (1) year from the date of signature.

By checking this box, you authorize The Speech & Hearing Center to periodically send you, via email or U.S. mail, helpful information related to communication disorders, special promotions the Center may have to offer, and/or information about special fundraising events to benefit the Center.

Signature of Consenting Party

Relationship to Patient
(must be legal guardian/conservator)

Date

CONSENT TO COMPLY WITH FEDERAL HIPAA ACT
Patient Consent for Use and Disclosure of Protected Health Information

With my consent and signature, the Speech and Hearing Center may use and disclose protected health information about me or my child to:

1. Carry out treatment, payment, and healthcare operations (services).
2. Call my home or other designated locations and leave a message on voice mail in reference to any items (i.e. appointment reminders, insurance items, references to clinical care of laboratory results, etc.) that will assist in the practice of medical care for me or my child.
3. Mail to my home or other designated address any item (i.e. appointment reminder cards, patient financial statements, etc.) that will assist in practice of medical care for me or my child. Such correspondence is to be marked personal and confidential.
4. Send or transmit email to any location provided by me for all above similar items and purposes.
5. To use and/or disclose protected health information about me or my child to/with third parties involved in mine or my child's care. Such parties may include, but are not limited to, insurance companies, hospitals, specialty physicians, and laboratory personnel. I may specifically describe the type of information (i.e. dates of services, level of detail, origin of information, etc.) subject to disclosure and may revoke this permission at a time and date chosen by me. By providing a written statement to the privacy office of the Speech and Hearing Center, I may revoke this permission; however, the Speech and Hearing Center may decline to provide further treatment to me or my child. The speech and hearing center may also decline further treatment to me or my child should my restrictions on the type of third party information, in the center's opinion, impede medical care of me or my child.

I have the right to review the Notice of Privacy Practice Manual of the Speech and Hearing Center. The Speech and Hearing Center may revise its manual and procedures at any time deemed necessary, and I may request from time to time, in writing, a copy of such changes, should these changes directly relate to mine or my child's care.

I have the right to request that the Speech and Hearing Center restrict how it uses or discloses mine or my child's health information. However, as state previously, the Speech and Hearing Center is not required to agree to my restrictions. If the Speech and Hearing Center accepts my restrictions, the Speech and Hearing Center is then bound by the restriction in the agreement, setting forth the restricted information until providing me, in writing, a cessation of such agreement.

I may revoke this entire consent, in writing, at any time. If I do not sign this consent, or revoke this consent, the Speech and Hearing Center, in their sole discretion, may decline further treatment for me or my child.

The Federal HIPAA (Privacy Act) of 2001 was created to protect mine and my child's health information. I understand this must be accomplished within the provisions and rules set up by the Speech and Hearing Center to fulfill federal law.

I may request to review the manual which spells out these provisions. The Speech and Hearing Center will comply with this law to preserve privacy. If compliance with this law impedes the medical care of the patient, the Speech and Hearing Center may decline to provide further care. The Speech and Hearing Center will strive to provide information so that I may make an informed decision concerning the privacy of mine or my child's medical information.

Signature of Parent or Legal Guardian of Minor Child

Patient's Name

Date of Birth

Date of Signature

Printed Name of Signature Above

Initials of Witness

Medication Form

Patient's Name: _____ Date: _____

Please fill out required information regarding ALL MEDICATIONS: PRESCRIPTION, OVER THE COUNTER, VITAMINS, AND DIETARY/ HERBAL SUPPLEMENTS below COMPLETELY.

I am currently NOT taking any of the above

Medication: Prescription, Over the Counter, Vitamins, Herbals, Dietary Supplements	Dosage	Frequency (times per day)	Route (Oral, Injectable, Transdermal, Inhale) Patients with Medicare Must complete	Reason for Medication

Smoking History:

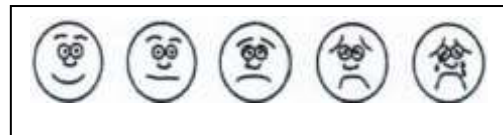
Current smoker: _____

Packs per day: _____

Former smoker: (Quit Date: _____)

Never smoked: _____

Please indicate your level of pain:



0	2	4	6	8	10
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

Patient Signature: _____ Printed Name: _____ Date: _____



Financial Policies Review

Thank you for choosing The Speech and Hearing Center for your speech and audiology needs.

General Financial Policy of the Center:

The Speech and Hearing Center is a non-profit organization providing services for the community for both those in need and those who are able to afford our services. In order to keep our administrative costs as low as possible, we require payment at the time of services and do not send out billing statements. The Center will provide notification of a missed payment as early as possible by sending a statement that is due upon receipt.

If we participate with a commercial insurance plan under which you are covered, we will bill the carrier charges for all covered, medically necessary services rendered. Your signature authorizes payment of medical benefits to the provider when an assigned claim is filed. You will be responsible for deductibles, copayments and any non-covered services at time of service.

If we do not participate with your commercial insurance plan or you do not have insurance, you will be responsible for payment in full at time of service.

We accept Visa, MasterCard, Discover, American Express, personal checks and cash. Financing is also available through Care Credit.

If a patient is seen off site or attends appointments without the financially responsible person, the Center requires that a credit card be on file to process payment for services on the day or the day following the provided service.

Speech Therapy patients: The Center will file insurance for in-network BCBS, BlueCare, United Healthcare and Medicare patients, but often developmental speech services are not covered by commercial insurance plans. The Center will not continue to file claims for services that are determined to be uncovered by an insurance provider. Uncovered services are not applicable to your deductible for most plans and you will be responsible for payment at time of service.

Received and Acknowledged by Patient or Responsible party:

Signature: _____

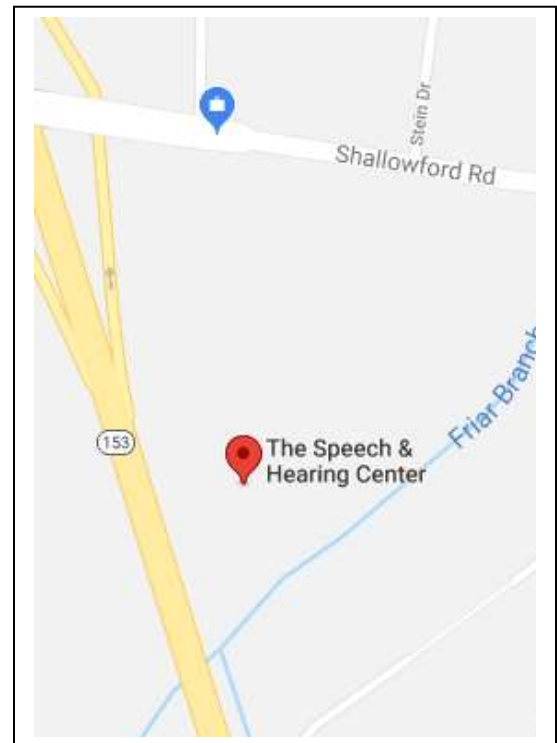
Name: _____

Date: _____



Directions to the Speech and Hearing Center

The Speech and Hearing Center
6016 Shallowford Road
Suite 1500
Chattanooga, TN 37421
423.622.6900



Directions from Highway 153 South (from Hixson):

- Take Exit 2- Shallowford Road
- Stay in left two lanes to turn onto Shallowford Road
- Turn right on the service road across from Waffle House just before Service King
- Stay right at the median and continue around the bend until you see Car Express on your left
- Our building is located to the left of Ankar's Express Café at Friar's Branch Crossing

Directions from Highway 153 (from I-75)

- Take Exit 2- Shallowford Road
- At the light turn right onto Shallowford Road
- Turn right on the service road across from Waffle House just before Service King
- Stay right at the median and continue around the bend until you see Car Express on your left
- Our building is located to the left of Ankar's Express Café at Friar's Branch Crossing