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Thank you for making your appointment with The Speech and Hearing Center on
________________________________at ________________________________

Enclosed in this package is an Intake Form, Case History, Consent to Exchange Information, Consent to Comply with Federal HIPAA Act, Financial Policies Review 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 help us get you started on time for your scheduled 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 our 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 or Audiologist.

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

Thank you,

The Speech and Hearing Center

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________ Zipcode______________

HomePhone:______________WorkPhone:______________MobilePhone:______________

Social Security#______________ DOB______________ Sex: M or F Email:______________
(Circle)

Marital Status: Married Single Other (Circle) Employment Status:Full-time Part-Time None (Circle) Student Status:Full-Time Part-Time None (Circle)

Referring Physician:______________ Primary Physician:______________

Emergency Contact:______________How did you hear about us?______________

PRIMARY INSURANCE INFORMATION(*If patient is also the Insured, enter"SAME" for name & address)*

Insured's Name:____
First Initial Last

Address:____

City:______________State:__________Zipcode______________

HomePhone:______________WorkPhone:______________MobilePhone:______________

Patient Relation to Insured Self Spouse Child Other (Circle) Insured DOB______________ Insured Sex: M or F (Circle)

Insured Employment Status: Full-Time Part-Time None (Circle) Insured Employer:______________

Insurance Co. Name:______________ Subscriber ID Number:______________Group Number:__________

OTHER INURANCE INFORMATION(*If patient is also the Insured, enter"SAME" for name & address)*

Insured's Name:____
First Initial Last

Address:____

City:______________State:__________ Zipcode______________

Home Phone:______________Work Phone:______________ Mobile Phone:______________

Patient Relation to Insured: Self Spouse Child Other (Circle) Insured DOB______________Insured Sex: M or F (Circle)

Insured Employment Status: Full-Time Part-Time None (Circle) Insured Employer:______________

Insurance Co. Name:______________ Subscriber ID Number:______________Group Number:__________

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______________

6016 Shallowford Road, Suite 1500
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PH: 423-622-6900 FX: 423-622-

ADULT SPEECH CASE HISTORY – CONFIDENTIAL INFORMATION

NAME:____TODAY'S DATE:___________________
DATE OF BIRTH:_________________________AGE:_______________SEX:____MALE ____FEMALE
OCCUPATION:_________________________________EDUCATION:____________________________
______PRESENTLY EMPLOYED ______RETIRED ______UNEMPLOYED
MARITAL STATUS: ______SINGLE ______MARRIED ______WIDOWED ______DIVORCED
NAME OF SPOUSE OR NEAREST RELATIVE____
WHO REFERRED YOU TO THE SPEECH AND HEARING CENTER?____________________________________
REASON FOR REFFERAL?____
____

PLEASE PROVIDE (IN THE SPACE BELOW) A LIST OF PLACES WHERE YOU HAVE HAD PREVIOUS EVALUATIONS OR THERAPY:
NAME:____________________ADDRESS:________________________________DATE:_____________
NAME:____________________ADDRESS:________________________________DATE:_____________

NAME/ADDRESS OF PHYSICIAN:____

EXISTING OR PREVIOUS DIAGNOSIS:____

PLEASE ANSWER THE FOLLOWING QUESTIONS, WHEN APPLICABLE:
PLEASE DESCRIBE YOUR PRESENT SPEECH PROBLEM:____
____

WHAT DO YOU THINK CAUSED YOUR SPEECH PROBLEM?____
____

HAS THE PROBLEM BECOME WORSE OR HAS IT SEEMED TO IMPROVE? PLEASE EXPLAIN.
____
____

WHAT CONDITIONS SEEM TO MAKE THE PROBLEM BETTER OR WORSE?

____

____

HOW DOES SPEECH AFFECT YOUR JOB OR OTHER ASPECTS OF YOUR LIFE THAT REQUIRE COMMUNICATION? PLEASE EXPLAIN (FOR EXAMPLE, DO YOU WITHDRAW FROM COMMUNICATIVE SITUATIONS BECAUSE OF YOUR PROBLEM, OR HAS IT AFFECTED YOUR CHOICE OF A JOB?)

____

____

DO OTHER MEMBERS OF YOUR FAMILY HAVE A SIMILAR PROBLEM OR OTHER SPEECH PROBLEM? PLEASE EXPLAIN.____

____

WHAT STRATEGIES HAVE YOU USED AT HOME TO WORK ON THIS PROBLEM?_______________________

____

HAVE YOU RECEIVED ANY HELP FOR THIS PROBLEM (SPEECH PATHOLOGISTS, DOCTORS OR OTHER PROFESSIONALS?) PLEASE EXPAIN.____

____

HAVE YOU HAD ANY SERIOUS ACCIDENTS? IF SO, PLEASE EXPLAIN.______________________________

____

HAVE YOU HAD ANY CHRONIC ILLNESSES? IF SO, PLEASE EXPLAIN.______________________________

____

HAVE YOU EVER BEEN HOSPITALIZED? IF SO, PLEASE EXPLAIN._________________________________

____

PLEASE INDICATE ANY SURGERIES OR ILLNESSES RELATED TO THIS SPEECH PROBLEM.________________

____

DO YOU HAVE ANY DIFFICULTIES WITH YOUR HEARING?__________________________________

____

PLEASE DESCRIBE ANY PHYSICAL DISABILITIES.______________________________________

____

SIGNATURE OF PERSON COMPLETING THIS FORM:_________________________________

_____SELF _______SPOUSE **DATE:**__________________________

_______FAMILY _______OTHER

THE
SPEECH & HEARING
CENTER
Enhancing Communication. Enriching Lives.

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:___YES____NO
Packs Per Day_______
Former Smoker(Quit Date:)_________
Never Smoked:____________

PLEASE INDICATE YOUR LEVEL OF PAIN

Patient Signature:______________________________ Date:____________________
Printed Name:______________________________

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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 and 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

6016 Shallowford Road, Suite1500
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PH: 423-622-6900 FX: 423-622-4834

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 or 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 stated 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 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	Date of Signature
______________________________	______________
Patient's Name	Date of Birth
______________________________	______________
Printed Name of Signature Above	Initials of Witness

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 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, co-payments 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:____

THE
SPEECH & HEARING
CENTER
Enhancing Communication. Enriching Lives.

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 the 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 office 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 the 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 office is located to the left of Ankar's Express Café at Friar’s Branch Crossing