____

____

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

THE SPEECH & HEARING CENTER
Enhancing Communication. Enriching Lives.

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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CHILD HEARING CASE HISTORY – CONFIDENTIAL INFORMATION

Child's Name:____Date of Birth:______________________________
Person answering these questions:_______________________________Relationship to Child:______________
Who referred you to The Speech and Hearing Center:?______________________Today's Date:_____________
Name of Child's Pediatrician:____

PLEASE CHECK "YES" OR "NO" TO THE FOLLOWING QUESTIONS

YES	NO	
___	___	Has the child had any problems with ear infections? Number of infections per year___________
___	___	Has there been any drainage from the ears?
___	___	Has the child ever had tubes? Number of sets____________
___	___	Ear Surgery? Date of Surgery(s)____
___	___	Was the child full-term?
___	___	Did the child's mother have any kind of illness or medical problems during her pregnancy?
		If YES, please describe:____
___	___	Did the child's mother take any medications during her pregnancy?
		If YES, please list medications:____
___	___	Was the child born with or has the child developed any medical problems?
		If YES, please describe:____
		____
		____
___	___	Does the child have a speech problem?
		If YES, please describe:____
___	___	Does the child have a hearing problem?
		If YES, please describe:____
___	___	Do any of the child's family members have a hearing problem?
		If YES, please describe:____
___	___	Do any family members wear hearing aids?
		If YES, please describe:____
___	___	Does the child wear a hearing aid(s)?
___	___	Does the child frequently turn the TN or radio too loud?
___	___	Does the child frequently ask for things to be repeated?
___	___	Does the child seem inattentive or withdrawn at home or school?

ANSWER THE FOLLOWING QUESTIONS IF THE CHILD IS FOUR YEARS OF AGE OR YOUNGER

YES	NO	
___	___	When the child is sleeping, do sudden noises awaken him/her momentarily?
___	___	Does the child cry at very loud noises?
___	___	Does the child ever jump to sudden loud noises?
___	___	Did the child babble around 5 or 6 months of age?
___	___	Did the child look for sounds behind him/her at 13 months of age?
___	___	Did the child begin to imitate some sounds at 9 to 13 months of age?
___	___	Does the child hear you when you call from another room?

ANSWER THE FOLLOWING QUESTIONS IF THE CHILD IS OF SCHOOL-AGE

YES	NO	
___	___	Is the child having problems with his/her school work?
___	___	Are there any problems with spelling, phonics or English?
___	___	Is the child able to hear when there is background noise?
___	___	Is the child able to discriminate between words?
___	___	Is the child able to discriminate words in a noisy environment?
___	___	Is the child able to remember a series of numbers, words or sentences in order?
___	___	Is the child able to correctly follow a series of oral directions?
___	___	Does the child confuse the order of words or syllables, such as saying "cakecup" for "cupcake"?
___	___	Is the child able to remember the alphabet, days of the week, months of the year, etc?

CHECK ALL THAT APPLY

___Frequent Colds
___Measles
___Encephalitis
___Diabetes
___Tonsillitis
___Mumps
___Chicken Pox
___Tonsils/adenoids removed
___Heart Problems
___High Fever

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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

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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

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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