Pathway Audiology

Patient Information

Demographics:

Patient Name _____ Date of Birth _____/_____/_____ Male Female

Address _____ City _____ State _____ Zip _____

Parent/Guardian Name_____ Phone Number (_____) _____-_____

Parent/Guardian Preferred Method of Contact: Call Text Email

Primary Pediatrician_____ Phone Number (if known) (_____) _____-_____

Emergency Contacts: **Please include parent/guardian as named above in this section**.

Name_____ Phone (_____) _____-_____ Relation to Patient _____

Name_____ Phone (_____) _____-_____ Relation to Patient _____

How did you hear about us? Please circle all that apply and provide names where applicable.

Physician (specify) _____ Friend or Family Member (specify) _____

Mail Newspaper Website Google Facebook KBEST KBYG Other: _____

Patient Portal:

Please provide your email if you would like us to activate your child's secure, online patient portal where you can access reports, invoices, and other documents. You will receive an email with activation instructions.

Email _____

This form was signed by _____ Relation to Patient _____

Parent/Guardian Signature (Required**) _____ Date _____

Pathway Audiology

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your, or your dependent's, protected health information is used and disclosed for treatment, payment, or healthcare operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for use of the information for treatments, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

By signing this form, I understand that, unless indicated below, **Pathway Audiology, PLLC may call/leave a voicemail, text, or email to confirm appointments or relay important information regarding any appointments.**

_____ I **DO NOT** authorize Pathway Audiology to text or email appointment confirmations to the phone number or email I provided on the Patient Information form.

_____ I **DO NOT** authorize Pathway Audiology, PLLC to leave a voicemail with appointment information. Pathway Audiology, PLLC may still leave a voicemail asking me to call them back without leaving any additional information.

Please list any contacts that we are allowed to discuss or release records to (**please include yourself if filling out for your dependent**):

Name: _____ Relation: _____ Phone Number: (_____) _____-_____

Name: _____ Relation: _____ Phone Number: (_____) _____-_____

This consent was signed by: _____ (PLEASE PRINT)

_____ _____

Patient Signature **Date**

_____ _____

Staff Signature **Date**

Pathway Audiology

Patient Authorization

Clinical

1. I authorize Pathway Audiology, PLLC to perform all recommended/referred diagnostic procedures on myself or my dependent.
2. I authorize Pathway Audiology, PLLC to complete all measures needed to make a thorough diagnosis and recommendation. I authorize that such diagnostic material may be released to and/or obtained from third-party payors and/or other health professionals. This includes the primary care physician as listed on the Patient Information form, any physician who referred me or my dependent to Pathway Audiology, PLLC, and/or other healthcare professionals as specified on a medical release form, signed by me.

Financial

3. I authorize Pathway Audiology, PLLC to furnish all information regarding medical history, diagnosis, and treatment to my insurance company regarding a claim for benefits. If, however, said insurer fails to meet this obligation in whole or in part, or if I am non-insured, I agree to be responsible to the fee and cost involved in my treatment. I authorize payment of medical benefits to Pathway Audiology, PLLC and further understand that should my account have to be referred to a collection agency that I am responsible for all fees and costs incurred therein. I hereby authorize Pathway Audiology, PLLC to act on my behalf in accessing medical records when and if needed.

Insurance

4. I authorize Pathway Audiology, PLLC to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records and other diagnostic material about my medical history, services rendered, or recommended treatment. I authorize Pathway Audiology, PLLC to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company on my behalf and in my name listed as “signature on file”.
5. I certify that I, and/or my dependents, have insurance coverage with the insurance company listed on the card that I provided today and assign directly to Pathway Audiology, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
6. The above named may use my healthcare information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Patient Signature **Date**

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Patient's name: _____ Age: _____

Pediatric Case History

What is the primary reason for this appointment? Speech Delay Failed Hearing Screening
Other: _____

Audiologic History:

What were the results of your child's Newborn Hearing Screening? Pass Fail Unknown

Do you feel like your child's hearing is stable or fluctuates? Stable Fluctuates

Has your child's hearing ever been tested by an audiologist? Yes No
If yes, when was the most recent hearing test? _____ Where? _____
Results: _____

Has your child ever been evaluated by an Ear, Nose, and Throat (ENT) Physician? Yes No
If yes, name of ENT: _____ Where? _____
Results: _____

Does your child currently wear hearing aids? Yes No
If yes, how old are the hearing aids? _____ What brand? _____

Please check all of the following that apply to your child:

☐ Ear Deformity
Which ear? Right Ear Left Ear Both Ears

☐ Ear Drainage
Which ear? Right Ear Left Ear Both Ears

☐ Ear Pain
Which ear? Right Ear Left Ear Both Ears

☐ History of Ear Infections
Which ear? Right Ear Left Ear Both Ears

When was the most recent one? _____

Have they had more than 3 ear infections in one year? Yes No

☐ Ear Surgery/Ear Tubes
Which ear? Right Ear Left Ear Both Ears

How many sets of tubes or what kind of ear surgery: _____
Name of physician who placed tubes or performed surgery: _____

☐ History of Noise Exposure
Please describe: _____

☐ Other medical conditions of the ear: _____

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Pediatric Case History - Continued

Medical/Birth History: (Check all that apply)

☐ Measles ☐ Meningitis ☐ Mumps ☐ Allergies ☐ Influenza ☐ Chickenpox

☐ Head Injury ☐ Encephalitis ☐ Neonatal Intensive Care (NICU) for more than 5 days

☐ Hyperbilirubinemia (Jaundice) ☐ Anoxia (Oxygen Deprivation)

☐ Ototoxic Medications (e.g., Gentamycin, Aminoglycoside, Loop Diuretics)

☐ Infections at birth or in utero (e.g., Cytomegalovirus, Herpes, Rubella, Syphilis, Toxoplasmosis)

☐ Postnatal infections associated with hearing loss (e.g., Herpes, Meningitis)

☐ Genetic Syndromes/Conditions (e.g., Neurofibromatosis, Usher Syndrome, Waardenburg Syndrome, CHARGE Syndrome, Down Syndrome, Alport Syndrome, Treacher Collins Syndrome)

Family History:

Has anyone in your child's family been diagnosed with hearing loss before age 30? Yes No

If yes, what relation do they have to your child? _____

Educational History:

Is your child currently receiving services through: Early Childhood Intervention Special Education

If your child is school age, what school do they attend? _____

Do you have concerns about their performance in school? Yes No

If yes, describe: _____

Developmental History:

Does your child's development seem normal to you? Yes No

If no, describe: _____

Do you have concerns with your child's speech? Yes No

If yes, describe: _____

Circle any of the following therapies that your child receives:

Speech Occupational Physical Recreational Other: _____

Circle any of the following that your child has been suspected to have, diagnosed with, or treated for:

ADD/ADHD Autism Learning Disability Social or Emotional Issues

Patient's name: _____ Age: _____

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Pediatric Testing Questionnaire

Check all that apply:

- ☐ My child can repeat simple words such as cowboy, baseball, etc.
- ☐ My child can point to body parts such as ears, nose, eyes, hair, mouth, etc.
- ☐ My child can follow simple instructions such as "Drop the toy in the bucket."
- ☐ My child can point and identify certain pictures from a set.
- ☐ My child will wear 'over the ear' headphones.
- ☐ My child can follow instructions such as "Clap when you hear the beep." or "Give me a thumbs up when you hear the beep."

List interests that your child has: (e.g., Superheroes, Disney Princesses, Trains, etc.)

_____

_____

_____

Reports:

Who do we need to send the report of today's findings to? Pediatrician Early Childhood Intervention

Other: (Full Name & Fax Number) _____

_____ I agree to hold my child in my lap during testing, if necessary, to obtain the most accurate results.

By signing this form, I understand that testing a child's hearing may take several appointments depending on the attention span and willingness of the child to follow instructions. **I attest that I have completed the above questionnaire to the best of my ability to help the audiologist determine the best method for testing my child.**

This questionnaire was completed by:_____ (PLEASE PRINT)

_____ _____

Parent/Guardian Signature **Date**