Dr. Jamie Lantz – Professional Hearing Center
4257 Route 9 North, Bldg. 6, Suite B
Freehold, NJ 07728

PEDIATRIC HISTORY - AUDIOLOGY

Child's Name: _____

Address: _____City:_____

State: _____Zip Code: _____Phone #:_____

Date of Birth: _____ Age: _____ Gender/Sex: ___Male ___Female

Child resides with: ____Both Parents ___Mother ___Father ___Other_____

Email Address:_____

Mother's Name: _____ DOB: _____
Home #: _____Cell#: _____Work #: _____
Mother's Address: _____
(If different than patient's)

Father's Name: _____ DOB: _____
Home #: _____ Cell #: _____Work #: _____
Father's Address: _____
(If different than patient's)

BILLING GUARANTOR (HOLDER OF INSURANCE)
Insured's Name: _____DOB:_____
Employer Name: _____ Phone #:
_____
Employer Address: _____

Primary Ins. Company: _____

Secondary Ins. Company: _____

PLEASE SIGN: Patient's signature for the release of medical information.
I authorize the release of information necessary to file a claim with my insurance carrier and request payment of benefit to either the audiologist or myself if her fee has not been paid. I understand I am financially responsible for my balance not covered by my insurance carrier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services.

Signature_____**Date**_____ **Referred by**_____

Child's Name: _____

Pediatrician's Name: _____ Phone#: _____
Pediatrician Address: _____

Primary Concern: _____

_____

_____

Medical History

Does child have a history of frequent ear infections? ___Y ___N How many_____?
Did child pass newborn screening? ___Y ___N

Birth History:
Length of pregnancy (in weeks)_____
Was pregnancy: _____unremarkable _____complications

Please write down all complications:_____
_____

Did the baby have any of the following at birth or shortly after birth?
___Jaundice/High bilirubin levels ___Low APGAR score ___Birth trauma
___Low birth weight ___Hydrocephaly ___Cerebral bleeds ___Addicted to drugs
___Toxic effects ___Anoxia/loss of oxygen to brain ___ lead poisoning ___other

Please explain_____
_____

Has child been hospitalized since birth? ___Y ___N
If yes, please list approximate date or age and reason for hospitalization:_____
_____

Has child undergone any surgeries?
_____

Were developmental milestones met on time?

Sitting	___Y	___N	age_____
Walking	___Y	___N	age_____
Talking	___Y	___N	age_____

If not, please explain_____

After developmental milestones were attained, was there any regression. (I.e. did child start to talk and then suddenly stopped)? ___Y ___N

Are there currently any speech or language difficulties ___Y ___N

___Expressive skills ___Receptive skills ___Global language delay
___Articulation difficulties ___Phonic difficulties ___Pragmatic skills

Was child ever diagnosed with any of the following?

Your answer **should be N/E** unless the diagnosis has been made (**Y**) or ruled out (**N**)

Central Auditory Processing Disorder (CAPD)	___Y	___N	___Not Evaluated
Learning Disability (LD)	___Y	___N	___Not Evaluated
Attention Deficit Disorder (ADD)	___Y	___N	___Not Evaluated
Attention Deficit Hyperactivity Disorder ADHD	___Y	___N	___Not Evaluated
Pervasive Developmental Disorder /Autism	___Y	___N	___Not Evaluated
Intellectual Disability (ID/MR)	___Y	___N	___Not Evaluated
Asperger's syndrome	___Y	___N	___Not Evaluated
Sensory integration deficit	___Y	___N	___Not Evaluated
Dyslexia	___Y	___N	___Not Evaluated
Is there family history of the above ?	___Y	___N	___Not Evaluated

Please list all: _____

Does the child wear glasses? ___Y ___N

Did the child undergo a complete Visual Processing evaluation by an ophthalmologist?
___Y ___N

If yes, what visual disorders have been identified?_____

Does child have a history of frequent ear infections? ___Y ___N How many_____?

Does the child have history of?

___Head trauma ___Tubes in the ears ___High fevers ___Hospitalization
___Ear infections ___Seizures/Epilepsy ___Hearing loss ___Allergies
___Broken bones ___Meningitis ___Enlarged adenoids/tonsils
___Diabetes ___Lead poisoning ___Concussions

Explain and provide dates/and or child's age: _____

Did the child have the following tests: ___MRI ___CT scan ___EEG

Have any of the following evaluations been performed?

Speech & Language	___Y ___N	___Currently undergoing	Date of Eval._____
Neurological	___Y ___N	___Currently undergoing	Date of Eval._____
Psychological	___Y ___N	___Currently undergoing	Date of Eval._____
Psycho-educational	___Y ___N	___Currently undergoing	Date of Eval._____
Neuropsychological	___Y ___N	___Currently undergoing	Date of Eval._____
Visual processing	___Y ___N	___Currently undergoing	Date of Eval._____

Please provide results of the last psycho-educational evaluation, speech and language evaluation and /or IEP.

Educational History

Current school:_____ Current grade:_____

What grade is the child going into next academic year? _____

Does the TEACHER report that child is:

____inattentive	____impulsive	____does not listen
____walks around	____daydreams	____does not follow directions
____disruptive in class	____slow to get started	____looks around before doing work
____seems confused	____disorganized	other: _____

Does the child receive any special education services privately or in school?

Speech Therapy/ Occupational Therapy/ Physical Therapy/Counseling

Does the child currently use or has ever used an FM system? ___Y ___N

If yes, is any benefit noted with the use of the FM system? ___Y ___N

Does the child receive special accommodations in school? ___Y ___N

___extended time on tests	___does not use scantron to record answers
___separate location for test taking	___modified homework
___tested in small group	___note taker or teacher's notes provided
___instructions read and re-read	___takes tests in the back of class
___use of assistive technology	___other_____
___books on tape	
___lap-top/notebook computer	

Notice of Privacy Practices

I give permission to Professional Hearing Center to release information, verbal and written, contained in my medical records and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons.

I authorize Professional Hearing Center to use and release my protected health information, i.e., my contact information, for marketing/email/newsletters related to hearing care products or services.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.

I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge, and hereby give my Professional Hearing Center permission to treat my concerns.

Name:_____ Date:_____

I authorize Professional Hearing Center to release information to the following:

Physician Name_____
Address_____
Phone number _____

Other:_____
Address_____
Phone number _____

Other persons authorized to discuss and or receive my health information:

I authorize the staff or audiologist at Professional Hearing Center to discuss my healthcare, diagnosis, test results, procedures, prognosis, insurance and billing information with the following person(s) for the purpose of my treatment or payment of services rendered.

Name:_____ Relationship_____ Phone _____

Name:_____ Relationship_____ Phone _____

Name:_____ Relationship_____ Phone _____

Patient Signature _____ Date: _____

Medication Record

Patient Name:_____

Date of Birth:_____

Medication	Dosage	Frequency (i.e. 2 x per day)	Route (pill, Injection)	Reason

Additional Comments/Concerns

_____

_____

_____

_____

_____

_____

_____

Audiologist Signature:_____ Date:_____

HEALTH INSURANCE PORTABILITY & FINANCIAL ACCOUNTABILITY ACKNOWLEDGMENT: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

I. Professional Hearing Center is required by law to protect the privacy of my health information, often referred to as protected health information or PHI, which may include individually identifiable information that relates to my past/present/future physical or mental health condition and provision of health care and/or past/present/future payment for health care.
Upon request, Professional Hearing Center will provide me with a copy of this notice describing the privacy practices and legal duties and to explain how, when, and why Professional Hearing Center may use or disclose my protected health information.

II. HOW PROFESSIONAL HEARING CENTER MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION

The following categories describe different ways that Professional Hearing Center may use or disclose medical information about you. For each category, we have provided useful examples:

- **Treatment** means the provision, coordination, or management of your health care, including consultations between doctors, nurses, and other providers, regarding your care and referrals for care from one provider to another. For example, your ENT doctor may disclose your protected health information to the audiologist if he/she is concerned that you have an auditory problem.
- **Payment** means the activities Professional Hearing Center carries out to bill and collect for the treatment and services provided to you. For example, Professional Hearing Center may provide information to your insurance company about your medical condition to determine your current eligibility and benefits. We may also provide PHI to outside billing companies and others that process health care claims.
- **Health Care Operations** means the support functions that help operate Professional Hearing Center such as quality improvement studies, case management, responding to patient concerns, and other important activities. For example, Professional Hearing Center may use your PHI to evaluate the performance of the staff that cared for you or to determine if additional services are needed.

III. OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

In addition to using and disclosing your protected health information for treatment, payment, and health care operations, Professional Hearing Center may also use your information in the following ways:

- **Appointment Reminders and Health-Related Benefits or Services.** Professional Hearing Center may use PHI to contact you for a medical appointment or to provide information about treatment alternatives or other health care services that may benefit you. This may include receiving emails, text messages, and phone calls regarding services from Professional Hearing Center and affiliates.
- **Disclosures to Family, Friends, and Others.** Professional Hearing Center may disclose your PHI to family, friends, and others permitted and identified by you as involved in your care or the payment of your care. Professional Hearing Center may use or disclose PHI about you to notify others of your general condition. We may also allow friends and family to pick up goods related to your hearing health when determined that it is in your best interest to do so. If you are available, we will give you the opportunity to object to these disclosures.
- **To Avoid Harm.** As permitted by law and ethical conduct, we may use or disclose protected health information if we, in good faith, believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public, or is necessary for law enforcement to identify or apprehend an individual.
- **Fundraising & Marketing Activities.** Professional Hearing Center may contact you as part of any fundraising or marketing activities as permitted by law.
- **Research Purposes.** In certain circumstances, we may use and disclose PHI to conduct medical research. Certain research projects require an authorization which will be made available to you prior to using your PHI.
- **Lawsuits & Disputes.** If you are involved in a lawsuit or dispute, Professional Hearing Center may disclose health information about you in response to a court or administrative order. We may also disclose health information in response to a subpoena, discovery request, or other process by others involved in the dispute. Professional Hearing Center will only disclose information with assurance that efforts were made to inform you about the request or to obtain an order protecting the information requested.
- **Required by Law Enforcement.** Professional Hearing Center may release health information about you if asked to do so by law enforcement in response to a court order, subpoena, warrant, summons, or similar process. We also may disclose information to identify or locate a suspect, fugitive, material witness, or missing person. In addition, we may disclose information about a crime victim or about a death we believe may be the result of criminal conduct. In emergency situations, we may disclose PHI to report a crime, to help locate the victims of the crime, or the identity/description/location of the person who committed the crime.
- **Incidental Disclosures.** Professional Hearing Center may make incidental uses and disclosures of your protected health information. Incidental uses and disclosures may result from otherwise permitted uses and disclosures and cannot be reasonably prevented. Having your name called aloud by a staff member in the waiting room is an example of an incidental disclosure.
- **Disaster Relief.** When permitted by law, we may coordinate our uses and disclosures of protected health information with other organizations authorized by law or charter to assist in disaster relief efforts. For example, a disclosure to the Red Cross or a similar organization.

IV. SPECIAL SITUATIONS

- **Military Personnel.** If you are a member of the armed forces, Professional Hearing Center may release PHI about you as required by military authorities. We may also release health information about foreign military personnel to appropriate foreign military authorities.
- **Worker's Compensation.** We may disclose health information about your work-related illness or injury to comply with Workers' Compensation laws.

- **National Security.** We may disclose PHI to authorized officials for national security purposes such as protecting the President of the United States or other persons, or conducting intelligence operations.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of law enforcement, Professional Hearing Center may release PHI about you to the correction facility or law enforcement officials. This would be necessary for the institution to provide you with health care; to protect your health and safety and the health and safety of others; or for the safety and security of the correctional institution.
- **Other Uses of Your Health Information.** You have the right to revoke the authorization at any time, provided the revocation is in writing, except if Professional Hearing Center has already taken action in reliance of your authorization.

V. YOUR RIGHTS

You have the following rights with respect to your protected health information:

Right to Request Limits on Uses and Disclosures of your PHI. You have the right to request restrictions to how Professional Hearing Center uses and discloses your PHI. Your request must be in writing and given to Professional Hearing Center.

Right to Request Confidential Communications. You have the right to request confidential communications of PHI by alternative means or at alternative locations. For example, sending information to your work address rather than to your home address, or asking that Professional Hearing Center contacts you by mail rather than telephone. To request confidential communications, you must specify these instructions in writing. You must specify where and how you wish to be contacted. Professional Hearing Center will accommodate all reasonable requests.

Right to Inspect and Obtain Copies of Your Protected Health Information. You have the right to inspect and obtain copies of protected health information used to make decisions about your care, subject to applicable law. If you request copies of your health information, Professional Hearing Center may charge a fee for copying, postage, and other supplies associated with your request.

Right to Amend Your Protected Health Information. If you believe that the protected health information we have about you is incorrect or incomplete, you may request that we amend the information. To request an amendment, you must make this request in writing to Professional Hearing Center, and specify a reason that supports your request. You are aware that Professional Hearing Center may deny this request for an amendment subject to applicable law.

The Right to Obtain a List of Disclosures. You have the right to request an "accounting of disclosures" of your protected health information.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services.

VI. FINANCIAL RESPONSIBILITY

I acknowledge and agree to the terms and conditions of this Agreement. I understand that this is a binding agreement and that I am responsible to pay for the services I receive at Professional Hearing Center in the event my insurance coverage does not cover the services. I understand that Professional Hearing Center rates do represent the Usual and Customary Rates for my geographical location, which may be higher than my insurance company's UCR.

SIGNATURES:

Name of Patient_____
Print

Name of Patient Representative_____
Print

Relationship of Patient Representative to Patient_____

Signature _____ Date _____

Witness to Signature _____ Date _____

Electronic Communication Agreement

Professional Hearing Center can provide our patients with certain types of information via e-mail and/or test messaging.

Professional Hearing Center believes strongly in protecting the privacy of our patients. We do not share the names, e-mails, and/or telephone numbers of patients with any other company or with any other patient.

In order to protect you privacy all confidential/personal information will only be sent via a secure email.

○ Professional Hearing Center can use secure email messaging to confirm my upcoming appointment and send confidential/personal medical information to my email address provided below.

Email Address:_____

○ Professional Hearing Center may send cell phone text messages to confirm upcoming appointments to my cell phone number provided below. I realize that normal text messaging rates may apply.

Cell phone number: ( )_____

○ I **DO NOT** consent to email and text message communication with Professional Hearing Center.

This release of information will remain in effect until terminated by me in writing.

Patient Signature:_____ Date_____