THE
SPEECH & HEARING
CENTER
Enhancing Communication. Enriching Lives.

Thank you for making your appointment with The Speech & Hearing Center.

Enclosed in this packet is all of your initial paperwork, along with 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:

- Email to frontdesk@speechhearing.com
- Fax to (423) 622-4834
- Mail to or in-person delivery at 2212 Encompass Drive, Suite 148, Chattanooga, TN 37421

Please arrive 15 minutes prior to your scheduled appointment time to allow extra time for intake, if you have not completed it before your appointment.

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

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PATIENT INFORMATION

Patient's Name: _____ Responsible Party: _____

DOB: _____ Relationship to Patient:_____

Home/Mobile Phone: (____)_____ ☐ Preferred Work/Other Phone: (____)_____ ☐ Preferred
Email: _____ County: _____

Address: _____ Apt/Unit Number: _____
City/St./Zip: _____

Emergency Contact: _____Emergency Contact Phone: _____
Relationship to Patient: _____

Gender: □ Male □ Female □ Other: _____

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Prefer Not to Answer

Race: □ American Indian or Alaska Native □ Asian □ Bi or Multi-Racial □ Black or African American
□ Hispanic or Latino □ Native Hawaiian or Other Pacific Islander □ White □ Prefer Not to Answer

Patient's Primary Care Physician: _____

How did you hear about us? □ Doctor's Office □ Friend □ Therapist/Teacher □ Flyer/ Newsletter
□ Web Search □ Social Media □ Insurance Company □ Other:_____

PRIMARY INSURANCE INFORMATION

Insured's Name: _____ Relationship to Patient: _____

Insured's DOB: _____ Insurance Company: _____

Subscriber ID: _____ Group No.: _____

SECONDARY INSURANCE INFORMATION

Insured's Name: _____ Relationship to Patient: _____

Insured's DOB: _____ Insurance Company: _____

Subscriber ID: _____ Group No.: _____

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Household Income

As a nonprofit, The Speech & Hearing Center receives grants that require we report demographic data to funders. In respect for your privacy, all data is anonymous, and HIPAA regulations are strictly followed.

Number of Individuals in Household: _____ Number that are Children:_____

Please check the box below that indicates your total household income.

Less than or equal to:
- □ $26,350
- □ $30,100
- □ $33,850
- □ $37,600
- □ $40,650
- □ $42,150
- □ $43,650
- □ $46,650
- □ $48,150
- □ $49,650
- □ $54,150
- □ $60,150
- □ $65,000
- □ $69,800
- □ $74,600
- □ $79,400
- □ Greater than $79,400

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CHILD HEARING CASE HISTORY – ABR

Child's Name:_____ Date of Birth:_____

Person Answering These Questions:_____ Relationship to Child:_____

Today's Date:_____ __ Name of Child's Pediatrician: _____

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

YES NO

___ ___ Was the child full-term? (39+ weeks)

___ ___ 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: _____

_____

_____

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Tennessee Department of Health
Newborn Screening Follow Up Program

Hearing Screen Only Form

Child's Last Name | First Name | Middle Name | Gender | (Twin: A or B) | Date of Birth

Birth Mother's Last Name | First Name | Maiden Name | **State Lab TDH#**

Address | City | State/Zip | Phone

Primary Care Provider | Phone

Birth Hospital Name: _____ City/State: _____

If this infant was TRANSFERRED, list hospital: _____

Person filling out form (print name): _____ Phone: 423-622-6900

Facility/Provider Name: The Speech & Hearing Center City: Chattanooga

RESULTS – INITIAL SCREEN:

Date of Initial Hearing Screen: _____/_____/_____ **Method:** ☐ABR/AABR ☐OAE

Results: **R**: ☐Pass ☐Refer **L:** ☐Pass ☐Refer **Risk Factors:** Mark in box at bottom

IF INFANT DID NOT PASS INITIAL SCREEN AND FURTHER EVALUATION (RESCREEN OR DIAGNOSTIC) WAS DONE:

Test done by: ☐Hospital ☐PCP ☐Audiologist ☐ENT/Otolary ☐Other_____

Date of Evaluation: _____**Type of Evaluation:** ☐ABR/AABR ☐OAE ☐Tymp/Reflex ☐ASSR ☐Behavioral

Results: **R**: ☐Pass ☐Refer **L:** ☐Pass ☐Refer

IF THIS INFANT WAS REFERRED TO: ☐Audiologist ☐ ENT ☐Other_____

Name: _____ Phone: _____ Appointment on: ____/____/____

Comments/Reason: _____

Risk Factors: (see below, check all that apply)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ A ☐ C ☐ D ☐ F

1. NICU >5 Days
2. Syndrome associated with progressive or late onset HL
3. Family History of permanent childhood hearing loss
4. Birth conditions or findings including microtia/atresia, ear dysplasia, cleft lip and/or palate, temporal bone abnormalities, white forelock, microphthalmia, congenital microcephaly, congenital or acquired hydrocephalus.
5. In-utero infections, such as CMV, Herpes, Rubella, Syphilis and Toxoplasmosis; Zika + Infant
6. ECMO
7. Asphyxia or Hypoxic Encephalopathy

A. Events associated with hearing loss including significant head trauma, (especially basal skull/temporal bone fractures) or chemotherapy
C. Aminoglycoside administration >5 days
D. Hyperbilirubinemia requiring exchange transfusion
F. Postnatal culture-positive infections associated with Sensorineural Hearing Loss, including confirmed bacterial and viral (especially Herpes virus and Varicella) meningitis and encephalitis.

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Consent to Exchange Information

We need your permission to share *any* information about your child with anyone who is **not your physician or a custodial parent/guardian**. If you want to consent for any information to be shared with another individual, please indicate their name and what information may be shared.

I hereby give my consent for The Speech & Hearing Center to exchange information with:

Name	Relationship to patient	Consent to accompany child to/from clinic, including appointment scheduling	Consent to access child's financial information, including insurance and account balance	Consent to access **all** of the child's medical information

Are you ok with identifiable information being communicated via:

Voicemail? □Yes □No Phone Number: _____

Email: □Yes □No Email: _____

Text? □Yes □No Phone Number: _____

Information exchanged may include, but is not limited to, speech therapy, occupational therapy, physical therapy, 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 valid until either a) discharge of the patient or b) written notice/update is provided with signature and date.

_____ _____

Signature of Patient/Responsible Party

Relationship to Minor Patient
(must be patient or legal guardian/conservator)

_____

Date

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Consent to Treatment

I _____(Patient or patient guardian if a minor) give permission for The Speech & Hearing Center (AKA the Center) to provide treatment to me/my child. Additionally, I grant them permission to file for insurance benefits for and communicate with my insurer regarding the care I receive. I understand that the Center will have to send my medical record information to my insurance company for these purposes.

In the event that my insurance does not cover part or all of my care from The Center, I understand that this financial responsibility will then pass to me. I agree to assume full financial responsibility for any partially or fully uncovered services.

I understand that I have the right to refuse treatment at any time and that I have a right to discuss all treatment with my clinician.

☐ Teletherapy Services

When possible or applicable, clinicians may choose to conduct appointments/sessions via telehealth or virtual modalities (i.e. Zoom). Please check this box to provide your consent to use of telehealth services when agreed upon by the clinician and responsible party.

_____ _____

Signature of Patient/Responsible Party

Relationship to Minor Patient
(must be patient or legal guardian/conservator)

_____

Date

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Patient Attendance Agreement

We are pleased to be enrolling _____ for services at our Center.

Our staff is dedicated to providing the highest quality services. You can help in the success of your treatment program by seeing that all appointments are promptly kept. Treatment is a commitment, and consistent attendance is necessary for progress in treatment.

We understand that illnesses and other circumstances do occur and may prohibit attendance at the last minute. In these cases, we ask that you call the office 24 hours in advance of your scheduled appointment and 48 hours in advance of any scheduled evaluation to notify us. If possible, a make-up session will be scheduled.

The Center will not allow more than three (3) non-emergent cancellations without advance notice in six (6) months from regular therapy and/or audiology sessions. These do not apply to cancellations made by the Center.

No shows cannot be tolerated, as there is a waitlist for services. The second (2nd) no show will result in immediate discharge from services.

Attendance is vital to the success of treatment. Your success is our primary interest; therefore, we ask for your assistance and cooperation so that we can reach milestones together.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I UNDERSTAND AND AGREE TO THE TERMS ABOVE.

_____ _____

Signature of Patient/Responsible Party

Relationship to Minor Patient
(must be patient or 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 & Hearing Center may use and disclose protected health information about me or my child to:

- Carry out treatment, payment and healthcare operations (services).
- 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.
- 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.
- Send or transmit email to any location provided by me for all above similar items and purposes.
- 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 & Hearing Center, I may revoke this permission; however, The Speech & Hearing Center may decline to provide further treatment to me or my child. The Speech & 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 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.

I have the right to review the Notice of Privacy Practice Manual of The Speech & Hearing Center. The Speech & 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 & Hearing Center restrict how it uses or discloses mine or my child's health information. However, as stated previously, The Speech & Hearing Center is not required to agree to my restrictions. If The Speech & Hearing Center accepts my restrictions, The Speech & 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 & 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 & Hearing Center to fulfill federal law. I may request to review the manual which spells out these provisions. The Speech & Hearing Center will comply with this law to preserve privacy. If compliance with this law impedes the medical care of the patient, The Speech & Hearing Center may decline to provide further care. The Speech & 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 Patient/Responsible Party

Relationship to Minor Patient
(must be patient or legal guardian/conservator)

_____

Date

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Financial Policies Review

The Speech & Hearing Center is a nonprofit organization serving both those in need and those who are able to afford our services.

Payment at Time of Service
In order to keep our administrative costs as low as possible, we require payment at the time of services. If a payment is missed, The Center will provide notification as early as possible by sending a statement that is due upon receipt.

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 of or the day following the provided service.

Insurance
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. 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.

Sliding Scale Fee Payment
For those who qualify based on income, and are without insurance coverage for services, a sliding scale fee system is available. Please call the office for more details.

Payment Methods
We accept credit cards, personal checks and cash. Financing is also available through Care Credit.

Financial Responsibility
I acknowledge by signing this document that should services/treatments not be covered by insurance (in whole or part) that I assume full financial responsibility for any and all costs.

Received and Acknowledged by Patient or Responsible Party:

_____ _____

Signature of Patient/Responsible Party

Relationship to Minor Patient
(must be patient or legal guardian/conservator)

_____

Date

THE SPEECH & HEARING CENTER
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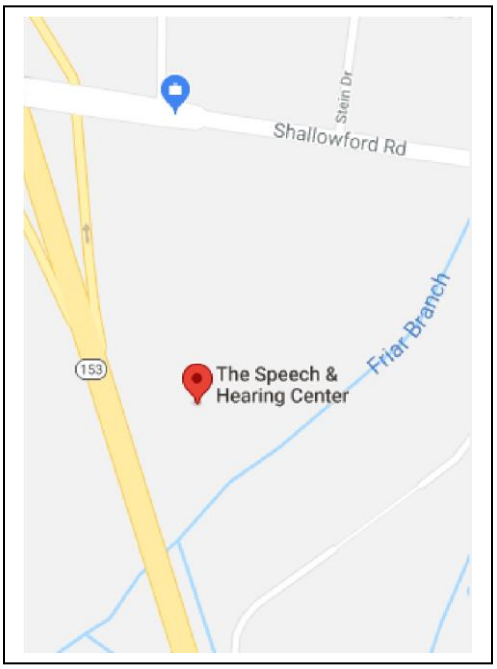
Directions to The Speech & Hearing Center

2212 Encompass Drive, Suite 148
Chattanooga, TN 37421



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 just after DriveTime but before the MAPCO gas station.
- Stay right at the median, and continue around the bend. You'll see RE/MAX and then Avenger Logistics on your left.
- Our office is in the corner of the last building 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 just after DriveTime but before the MAPCO gas station.
- Stay right at the median, and continue around the bend. You'll see RE/MAX and then Avenger Logistics on your left.
- Our office is in the corner of the last building at Friar's Branch Crossing.