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 THERAPY CASE HISTORY

Child's Name: _____ Date of Birth: _____ Today's Date _____

Does your child currently receive therapy services or has he/she in the past? □ Yes □ No
If yes, what services did he/she receive? □ Occupational Therapy □ Physical Therapy □ Speech/Language Therapy
For how long? _____ Name of past therapy provider/s?_____

What days/times are best for appointments? Please check applicable days and identify best times

Day	**Times (i.e. 8-12, mornings, afternoons)**
□ Monday	
□ Tuesday	
□ Wednesday	
□ Thursday	
□ Friday	

What are your concerns for today's appointment?_____
_____

Family History
Father's Name: _____ Age: ____ Education:_____
Employer: _____
Marital Status: __Single __Married __Divorced __Widowed __Separated

Mother's Name: _____ Age: ____ Education:_____
Employer: _____
Marital Status: __Single __Married __Divorced __Widowed __Separated

*If divorced, who has primary custody/decision making abilities? □ Mother □ Father □ Other: _____
(Please provide any court issued documentation or custody agreements)

Who does the child live with? □ Mother □ Father □ Step parent □ Siblings: #____ ☐ Other:_____

Any known family history of developmental or learning problems? □Yes □No
If yes, please describe:_____
_____

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Birth History

Complications / illness / infections / stress during pregnancy? □Yes □No
If yes, please describe: _____

Any complications during birth? □Yes □No
If yes, please describe: _____

Patient was born: □Term or Full Term (37+ weeks) □Premature (<37 weeks): _____ weeks
What is the order of the patient's birth? _____ (first, second, third, etc.)

Did the baby have a NICU stay? □ Yes □ No If so, how long? _____
If yes, please describe:_____

Physical Developmental History

Please note approximate age at which he/she did the following:

Milestone	Age	Milestone	Age
Rolled over		Buttoned Clothes	
Sat		Tied shoelaces	
Crawl (on belly)		Toilet trained	
Creep (on hands and knees)		Dressed self	
Walked		Undressed Self	
Stair Climbing		Used two-word sentences	
Ran		Used three-to-four-word sentences	
Drank from cup		Fed self with utensil	

Speech and Language Developmental History

Milestone	Age	Milestone	Age
Coos		Answers simple questions verbally	
Smiles at people socially		Labels person/object with 2-3 words	
Vocalizes sounds differently (cries, laughs, giggles)		Imitates simple words	
Makes noise when talked to		Makes animal sounds ("moo," "bah")	
Babbles		Answers simple questions	
Says "ma-ma" or "da-da" intentionally or not		Uses inflected tone to indicate a question	
Mimics or repeats sounds		Spoke first sentence	
Says first word			

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Educational History

Present School Attending: _____ Grade: _____

Has your child…	Yes	No	Describe
Ever failed a grade?			Which grade:
Had serious difficulty in any grade or subject?			Which subject:
Had an intelligence test?			When:
Receiving special ed services?			Service:
Ever had an IEP?			If yes, for what service:

Comments about school:_____
_____

Speech and Language (If you have no concerns, please skip to the next section)

Describe the child's current speech/language problem: _____
_____

Describe the child's communication at the present time (Please check all that apply).

□ Grunts and Points □ Copies What You Say □ Do □ □ Stutters □ Gestures
□ Single Words □ Two Word Phrases □ Longer Sentences □ Screams
□ Takes You To Object □ Unclear Speech □ Too Soft □ Too Loud

Please describe any family history of speech/language problems:_____
_____

Please describe the results of any previous speech-language testing your child has had: _____
_____

Hearing (If you have no concerns, please skip to the next section)

Please describe any concerns: _____
Did child pass newborn hearing screening? □Yes □No

Has child been diagnosed with hearing loss? □Yes □No
If so, please describe: _____

Does child wear hearing devices (hearing aids/cochlear implants)? □Yes □No
If so, what? _____

Any family history of hearing loss? □Yes □No
If so, please describe: _____

History of ear infections or tubes? □Yes □No
If so, please describe: _____

Child's ENT: _____ Child's Audiologist: _____

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Visual History (If you have no concerns, please skip to the next section)
Has your child ever had a vision exam? □Yes □No

If so, what were the results? _____

	Yes	No
Wear glasses		
Tired eyes		
Contact lens		
Headaches		
Glare/light sensitivity		
Excessive eye rubbing		

Processing	**Yes**	**No**
Trouble learning left and right		
Reverses letters and numbers		
Mistakes word with similar beginnings		
Slow copying and completing worksheets		
Can respond orally but not in writing		
Trouble learning basic math concepts of size and magnitude		
Messy handwriting		
Doesn't recognize the same word repeated on a page		
Seems to know material but does poorly on written tests		
Poor reading comprehension yet good verbal comprehension		

Focusing and Tracking	**Yes**	**No**
Child turns head when reading or writing		
Covers one eye when reading		
Complains of words moving on page		
Holds book very close		
Loses place often		
Skips words or lines		
Uses finger to keep place		
Short attention when reading		
Complains of blurred vision when looking from desk to board		

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Feeding History (If you have no concerns, please skip to the next section)
Has your child ever had a feeding/swallowing assessment? □Yes □No

If so, what were the results?_____
_____

	Yes	No	Describe
Bottle fed as an infant			
Breast fed as an infant (please indicate how long)			
Difficulty latching and/or sucking			
Difficulty transitioning to purees			
Difficulty transitioning to solids			
Problems with chewing and/or swallowing			
Presence of gagging and/or choking when eating			
Picky eater			
Presence or history of a feeding tube			
History of reflux			
Problems with constipation and/or diarrhea			
Food allergies			

Sensory History (If you have no concerns, please skip to the next section)

	Yes	No	Describe
Has tantrums with transitions/changes in routine			
Overreacts/fearful of touch, noises, smells, etc.			
Is in constant motion, can't seem to sit still			
Unaware of being touched			
Does not understand verbal instructions			
Has difficulty following multi-step instructions			
Sudden mood changes and temper tantrums			
Frustrated and/or cries easily			
Avoids touching certain textures			
Avoids getting messy (finger paint, sand, glue, etc.)			
Refuses to wear certain types of clothing			
Mouths objects excessively (after age 2)			
Fearful of feet leaving the ground			
Walks on toes			

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Environmental and Psychological History

How well does he/she play with other children? _____

Nervous habits? □Yes □No If yes, please describe: _____

Sleeps well? □Yes □No Number of hours asleep without interruptions: _____

Does your child suck their thumb? □ Yes □ No Age stopped: _____

Eats well? □ Yes □ No Eats wide variety of foods? □ Yes □ No

Medications

List any current prescription or over the counter medications the patient may be taking.

Begin Date	**Prescription Name**	**Dosage/Frequency**

Medical Questions (Please answer to the best of your knowledge)

History (Check all that apply)

□ Asthma	□ Heart Condition	□ Rheumatism	□ Dizziness
□ Bronchitis	□ Hearing Impaired	□ Rheumatic Fever	□ Hepatitis
□ Cancer	□ High/Low Blood Cholesterol	□ Seizures	□ Thyroid Problems
□ Diabetes	□ High Blood Pressure	□ Shortness of Breath	□ Eye/Vision Problems
□ Frequent/Severe Headaches	□ Kidney Disease	□ Tuberculosis	□ Jaundice

What medical problems or conditions has the patient been diagnosed with? _____
_____

What other health or behavior problems does the patient exhibit? _____
_____

What past surgeries, hospitalizations or accidents has the patient incurred? _____
_____

Does the patient have any food or medication allergies that you are aware of? _____
_____

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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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Pickup, Drop-off, and Parent Presence

For liability purposes, we are unable to assume sole responsibility for your child before, during, and after therapy sessions/services. Parents or a parent-designated guardian are responsible for the safety of minor children at all times on the premises.

Minor children (under 18) may not be left unattended in the Center more than 5 minutes before or after their scheduled appointment time.

We encourage parents to attend therapy sessions, and observation rooms are available so that parents can both observe, and not feel they are distracting their child. A parent or guardian must accompany all children into the Center. However, if you choose not to attend therapy appointments, you, or the child's guardian, must remain either in the lobby, or in the parking lot in line of sight of the Center for the entire duration of the appointment.

If possible, a clinician can and will escort a child to you in the parking lot. Minor children will not be allowed to walk unattended from the Center into the parking lot.

Consistent delays in picking up children from appointments may result in remediation. If a child is consistently dropped off (3 or more times) too early for an appointment, the clinic supervisor will communicate to the parents that they are now required to come into the Center with the child until they are taken back for their appointment. Continued violation of this policy or refusal to comply may result in dismissal from services.

For a minor child, if a parent/guardian is not present within 5 minutes of the end of an appointment, the preferred number is to be called. The parent will be notified that children are not permitted to remain in the Center unattended. If after a verbal notification, additional instances (not related to emergency circumstances) occur, it will be required for parents to stay either in the therapy observation room or in the lobby for the duration of the child's appointments. Continued violation of this policy or refusal to comply may result in dismissal from services.

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 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

THE
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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 (2^{nd}) 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)

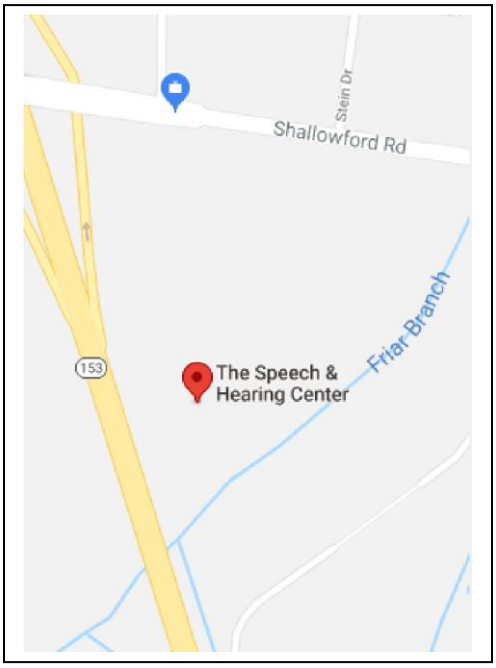
_____

Date

THE
SPEECH & HEARING
CENTER
Enhancing Communication. Enriching Lives.

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.
- 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.
- 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.