Swank Family Hearing

# Pediatric Case History

Patient Name: ______________________________
Last First MI

Preferred Name: ____________ Date of Birth: ____________ Pronouns: ____________

Daycare/School Currently Attending: ____________ Grade: ____________

Parent/Guardian Name(s): ______________________________

Relationship to Patient: ______________________________

Address: ______________________________
Street City State Zip

Home Phone: ____________ Cellphone: ____________

Email Address: ______________________________

Primary Care Physician: ______________________________

Insurance Company: ______________________________

Insurance Policy Number: ______________________________

Insurance Holder Name and Date of Birth: ______________________________

How did you hear about our clinic? ______________________________

**Please answer the following questions to the best of your ability:**

1. Birth History
   a. Prenatal Problems ☐ Yes ☐ No
      i. If yes, please describe: ______________________________
   b. Where was your child born? (Name of hospital or home birth): ______________________________
   ______________________________
   c. Premature Birth ☐ Yes ☐ No
      i. If yes, please describe: ______________________________
   d. Abnormal Apgar Scores ☐ Yes ☐ No
   e. Baby in ICU ☐ Yes ☐ No
      i. If yes, please describe: ______________________________
   f. Ventilation Required ☐ Yes ☐ No
      i. If yes, please describe: ______________________________
   g. Low Birth Weight ☐ Yes ☐ No
      i. If yes, please describe: ______________________________
   h. Did your child pass their newborn hearing screening? ☐ Yes ☐ No
2. Does your child have any current medical conditions? ☐ Yes ☐ No
   a. If yes, please list: ______________________________
3. Is your child currently on any medications? ☐ Yes ☐ No
   a. If yes, please list: ______________________________

4. Has your child ever had any ear infections? ☐ Yes ☐ No
   a. If yes, approximately how many? ______
   b. When was the most recent infection? ______
5. Has your child ever had tubes placed in their eardrums? ☐ Yes ☐ No
   a. If so, how many sets? ______
   a. When was the most recent set placed? ______
   a. Are they still in place? ☐ Yes ☐ No
6. Has your child had any other surgeries or outpatient procedures? ☐ Yes ☐ No
   a. If yes, please indicate the procedure and when it took place: ______

   ______
7. Do you currently have any concerns regarding your child's hearing? ☐ Yes ☐ No
   a. If yes, please describe: ______
   b. When did your concerns begin? ______
8. Has your child ever had their hearing tested? ☐ Yes ☐ No
   a. If yes, when and where? ______
   b. Please describe the results: ______
9. Does your child have any permanent hearing loss you are aware of? ☐ Yes ☐ No
   a. If yes, does your child use hearing aids? ☐ Yes ☐ No
10. Is there anyone in your family with hearing loss? ☐ Yes ☐ No
   a. If yes, who? ______
   b. What caused the hearing loss (e.g., age, illness, etc.)? ______
11. Does your child exhibit any of the following behaviors?
   a. Poor attention ☐ Yes ☐ No ☐ NA
   b. Sensitivity to loud sounds ☐ Yes ☐ No ☐ NA
   c. Turns to look for sounds ☐ Yes ☐ No ☐ NA
   d. Appears confused in noisy places ☐ Yes ☐ No ☐ NA
   e. Is overly dependent on visual cues ☐ Yes ☐ No ☐ NA
   f. Problems following directions ☐ Yes ☐ No ☐ NA
   g. Frequently requests repetition ☐ Yes ☐ No ☐ NA
   h. Gives inappropriate answers to simple questions ☐ Yes ☐ No ☐ NA
   i. Rarely participates in conversations ☐ Yes ☐ No ☐ NA
   j. Easily frustrated ☐ Yes ☐ No ☐ NA
   k. Often speaks too loudly ☐ Yes ☐ No ☐ NA
   l. Complains of ringing, buzzing or other noises in the head ☐ Yes ☐ No ☐ NA
12. Are there multiple languages spoken at home? ☐ Yes ☐ No
   a. If yes, what are they, and which one is the primary language used? ______

   ______
13. Has your child ever been tested for speech/language delays/difficulties? ☐ Yes ☐ No
   a. If yes, what was the outcome of the testing? ______
14. Any other developmental delays or disabilities we should be aware of? ☐ Yes ☐ No
   a. If yes, please describe: ______
   b. Name of diagnosing professional: ______
   c. Are copies of the diagnostic report available for review? ☐ Yes ☐ No
15. Any other concerns regarding your child's ears or hearing? ☐ Yes ☐ No
   a. If yes, please describe: ______

   ______

# HIPAA Policies

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

**Get a copy of your health and claims records:**

- You can ask to see or get a copy of your health and claims records and other health information we have about you.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request.
    - We may charge a reasonable, cost-based fee.

**Ask us to correct health and claims records:**

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

**Request confidential communications:**

- You can ask us to contact you in a specific way (for example, by home or office phone) or to send mail to a different address.
- We will consider all reasonable requests and must say “yes” if you tell us you would be in danger if we do not.

**Get a list of those with whom we’ve shared information:**

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you asked whom we shared it with and why.
- We will include all the disclosures except for those about treatment, payment and health care operations, and certain other disclosures.

**Choose someone to act for you:**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will ensure the person has this authority and can act for you before we take any action.

**How do we typically use or share your health information?**

- We use it to help manage the health care treatment you receive.
- We can share your information with professionals who are treating you.

**Pay for your health services:**

- We can use and disclose your health information as we pay for your health services.

**Administer your plan:**

- We may disclose your health information to your health plan sponsor for plan administration.

**Help with public health and safety issues:**

- We can share health information about you for certain situations, such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting suspected abuse, neglect or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety
  - We can use or share your information for health research
  - We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
  - Addressing workers' compensation, law enforcement and other government requests
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security and presidential protective services
  - Responding to lawsuits and legal actions
  - In response to a court or administrative order or in response to a subpoena

**File a complaint if you feel your rights are violated:**

You can complain if you feel we have violated your rights by contacting us.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave. SW, Washington, D.C. 20201, calling 1-877-696-6775 or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

We will not retaliate against you for filing a complaint.

For more information, see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

**Changes to the Terms of This Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and on our website, and we will mail a copy to you.

I have read and understand my HIPAA rights as outlined above. I acknowledge that I have the right to request a copy of this information and that a copy will be provided immediately.

______________________________________________ ____________________

Patient Signature Date

# Patient Rights

According to the American Speech-Language-Hearing Association, people receiving audiology services have the right to:

1. Be treated with dignity and respect
2. Services provided without regard to race, ethnicity, gender, age, religion, national origin, sexual orientation or disability
3. Know the name and professional qualifications of the person or persons providing services
4. Personal privacy and confidentiality of information to the extent permitted by law
5. Know, in advance, the fees for services, regardless of the method of payment
6. Receive a clear explanation of evaluation results, be informed of the potential or lack of potential for improvement and express their choices of goals and methods of service delivery
7. Accept or reject services to the extent permitted by law
8. Services provided in a timely and competent manner, which includes referral to other appropriate professionals when necessary
9. Present concerns about services and be informed of procedures for seeking their resolution
10. Accept or reject participation in teaching, research or promotional activities
11. To the extent permitted by law, review information contained in their records, receive an explanation of record entries upon request and request correction of inaccurate records
12. Adequate notice of, and reasons for, discontinuation of services; an explanation of these reasons, in person, upon request; and referral to other providers if so requested

# Patient Responsibilities

1. I am responsible for being considerate and treating the staff and other patients with respect; should I choose to be disrespectful, rude, belligerent, etc., Swank Family Hearing reserves the right to refuse service and refer me to another provider.
2. I am responsible (to the best of my knowledge) for providing accurate and complete information about present concerns, past illnesses, hospitalizations, medications and other information regarding my health.
3. It is my responsibility to know my insurance coverage and be aware of any referrals for services that I need; I am also responsible for getting any referrals from my primary care physician and providing a copy to Swank Family Hearing so my insurance can be billed.
4. I understand that payment is expected at the time of service, and I am fully responsible for all fees my insurance does not cover.

5. I understand if I am 10+ minutes late for my appointment, I will need to reschedule for a different day and time.

6. I understand Swank Family Hearing requires 24 hours' notice in the event of a cancellation.

    e. There is a $50.00 charge for a cancellation without 24 hours' notice, which insurance will not cover.

    e. We will review any emergencies and discuss a fee waiver on a case-by-case basis.

7. I acknowledge and understand the following policies regarding hearing aids:
    a. Wax Removal
        i. Insurance companies do not cover wax removal by an audiologist.
        ii. Should I agree to have wax removed from my ears, I will be charged $40.00 per ear.
    b. Out-of-Warranty Hearing Aid Services
        i. Clean-and-Check
            1. $15.00 for one hearing aid
            2. $25.00 for two hearing aids
        ii. Receiver/Speaker Replacement
            1. $125.00 each
        iii. Repairs
            1. Devices less than five years old
                a. $275.00 per hearing aid
            2. Devices more than five years old
                a. $375.00 per hearing aid
            3. Custom device repair (in-house)
                a. $125.00 per hearing aid

8. I authorize Swank Family Hearing to release my medical records to any referring physician, insurance company, health care facility or government agency requesting such information.

    a. I also authorize the release of my medical information to the following people:

        i. Name: ______________________ Relationship: ______________________

        ii. Name: ______________________ Relationship: ______________________

By signing below, I have read and agree to the above information.

______________________________ ______________________

Patient Signature Date

# Advanced Beneficiary Notice (ABN) Of Patient Responsibility

Please read and sign this ABN so you can make an informed decision about your hearing health care.

### Wax Removal

- Most insurance companies do not cover wax removal by an audiologist. Should I decide to have wax removed by an audiologist at Swank Family Hearing, I agree to pay $40.00 per ear for that service.

### Hearing Aids

- I understand Swank Family Hearing does its best to obtain accurate information regarding my hearing aid benefits from my insurance company. This information will be used to provide an estimate regarding the out-of-pocket cost of hearing aid technology and services.
- I understand all hearing aid pricing given at the appointment is an estimate, and the final out-of-pocket cost will be determined by my insurance company. I agree that I am responsible for any unmet deductibles set forth by my insurance. I also understand I will be billed any money more than what my insurance plan covers (detailed in your Explanation of Benefits), and I agree to pay all remaining charges.

______________________________ ____________________

Patient Signature Date