The University of Alabama – Speech & Hearing Center

OFFICE USE ONLY

FILE #_____

Speech Audiology

Section I: Patient Information (Please Print) Date_____

Name: Last _____ First _____ MI_____

Address_____ City_____ State_____ Zip_____

Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____

Date of Birth____/____/____ SSN#_____ Sex M/F

Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Primary Care Physician _____ Spouse or Parent's Name_____

Employer_____ Employer Address_____

Whom may we thank for referring you? _____

Person to contact in case of emergency_____ Phone(_____)_____

Email Address_____

Section II Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other Date of Birth_____/_____/_____

Name: Last_____ First _____ MI_____

Address_____

City_____ State_____ Zip_____ Phone (____)_____

Employer_____ Work Phone (____)_____ SSN#_____

Section III Insurance Information

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other Date of Birth_____/____/_____

Name of Insured: Last _____ First _____ MI_____

SSN#_____ Name of Employer_____ Work Phone (____)_____

Address of Employer_____ City_____ State_____ Zip_____

Insurance Company_____ Group #_____ ID#_____

DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other Date of Birth_____/_____/_____

Name of Insured: Last_____ First_____ MI_____

SSN#_____ Name of Employer_____ Work Phone (____)_____

Address of Employer_____ City_____ State_____ Zip_____

Insurance Company_____ Group #_____ ID#_____

Signature:_____ Date: _____

The University of Alabama
Speech and Hearing Center

Patient Financial Responsibility Statement

The UA Speech and Hearing Center is a fee-for-service clinic. All clients are expected to pay for speech-language evaluation and treatment services and audiological services. These services are provided by or under the direct supervision of certified speech-language pathologists and audiologists.

Speech-Language therapy and evaluation services. Blue Cross Blue Shield (BCBS) insurance may be billed for speech-language evaluation and treatment services if a client has a doctor referral for the services being requested. Clients who wish to file services with BCBS should check with their health care provider prior to their appointment to determine if the services being sought are covered. **Not all BCBS policies cover our services.**

Insurance verification for speech-language services will be completed as a courtesy for all clients prior to or at the time of their initial visit. However, clients are ultimately responsible for the payment of services. **Verification of benefits from your Insurance Company does not guarantee services are covered or will be paid by your insurance company.**

Medicaid claims may also be billed for speech-language evaluation and treatment services. All Medicaid clients must have a Medicaid referral form (EPSDT) from their primary care physician on file in the clinic prior to services being provided. **If a referral form is not provided prior to the service being rendered, no service will be provided.**

Clients who are uninsured, have an insurance provider not accepted by our clinic, whose BCBS policy does not cover our services, whose allowed insurance visitations have expired, or who receive group treatment services with flat program fees are classified as private pay clients. All private-pay clients are billed for services based on the clinic's established standard fee schedule for speech-language services

Audiology services. Insurance will not be billed for audiology services. All clients seeking audiology services are considered private-pay with the exception of those who have Medicaid. Medicaid claims may be billed for audiology services on behalf of clients under the age of 21 who have a valid Medicaid referral.

Speech-Language and audiology services are not provided to Medicare beneficiaries for medical necessary or Medicare covered services in the clinic due to Medicare billing and coverage requirements. Services may be billed directly to a Medicare beneficiary if: (1) the service is statutorily excluded, or (2) the Medicare beneficiary voluntarily requests Medicare not be billed for a covered service and an Advanced Beneficiary Notice is completed. **If you are a Medicare beneficiary please notify the front office prior to receiving any services.**

Filing insurance claims does not relieve you of financial responsibility for services rendered. Our office will bill you for any uncovered service(s) provided as well as any deductible amounts required by your policy. Co-pay is expected at the time services are rendered. If we are not filing a claim with your insurance company or Medicaid, you are expected to pay the cost of services at the time of service.

I UNDERSTAND THE ABOVE POLICY AND TAKE FINANCIAL RESPONSIBILITY FOR ANY CHARGES IF MY INSURANCE CANNOT BE BILLED OR DOES NOT COVER THE SERVICES PROVIDED.

Client Name _____ **Date** _____

Your Name _____ **Relationship** _____

Signature _____

THE UNIVERSITY
OF ALABAMA

SPEECH AND HEARING CENTER

Permission to Contact

I authorize the Speech and Hearing Center to leave messages for me regarding clinical services as specified below. These messages may include appointment reminders, schedule changes, or other private health information, including information about evaluation or treatment. It is your responsibility to notify us should this information change. **You do not have to check any of these options if they do not apply to you, or if you do not want us to communicate with you at these different locations.**

Circle yes or no

I give my permission for the Speech and Hearing Center to call me

Yes No at home # _____
Yes No at work # _____
Yes No on my cell phone # _____

I give my permission for the Speech and Hearing Center to leave a message

Yes No on my answering machine
Yes No on my voice mail
Yes No with the person who answers if I am unavailable

I give my permission for the Speech and Hearing Center

Yes No to leave a message with appoint/schedule information
Yes No to leave message with more detailed information

I give my permission for the Speech and Hearing Center

Yes No to mail written information to my home
Yes No to FAX to this number #: _____

The authorize following person(s) to have access to my Speech and Hearing Center records:

Person: _____ Relationship: _____

Person: _____ Relationship: _____

Confidentiality: It is our goal to keep you informed of your or your child's progress and test results. If you would like to discuss this information in a private location away from the waiting area, please inform your clinician. We will make every effort to respect the confidential nature of your services.

Client Name (Print): _____ Date: _____

Legal Representative Name (Print): _____

Signature: _____

Valid until discharged from services unless otherwise specified.
Revised 8/05

The University of Alabama
Speech and Hearing Center

Permission to Treat

I understand that the Speech and Hearing Center is a teaching clinic and that services are often provided by students under the supervision of a state licensed and nationally certified speech-language pathologist or audiologist.

MY PERMISSION IS GIVEN FOR DIAGNOSTIC AND INTERVENTION SERVICES AS DEEMED ADVISABLE BY MEMBERS OF THE SPEECH AND HEARING CENTER CLINICAL TEAM.

Client Name _____ **Date** _____

Your Name _____ **Relationship** _____

Signature _____

THE UNIVERSITY OF ALABAMA

SPEECH AND HEARING CENTER

Acknowledgement of Notice of Health Information, Recording, and Observation Practices

Our Notice of Health Information Practices is summarized below. Please review it carefully and sign it. Return this form to your clinician. The full version is available upon request or in our waiting room, and is yours to keep if you would like to have it. You can also access the Notice on-line at http://cd.ua.edu/speech-and-hearing-center/hipaa/ .

The Notice explains when we might use/disclose your clinical information, and includes some of the following examples:

- when you give us permission to disclose your clinical information
- to aid in your treatment or to persons involved in your clinical care or the payment for such
- to help us or other health care providers get paid for services provided to you
- to improve our clinical care operations
- for use by businesses with whom we contract to help provide administrative support, but only if they agree in writing to keep your information private
- to public health agencies, governmental agencies, or other entities or persons when required or authorized by law or when required or permitted to do so by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Since the Speech and Hearing Center is a training facility for students majoring in Communicative Disorders, it is common practice for evaluation or therapy sessions to be observed or recorded for the following teaching and collaborative purposes:

- review by the clinician and clinical supervisor to evaluate the clinician's performance
- review by the clinician and clinical supervisor to evaluate the client's progress and adjust services if needed
- review by clinical supervisors for collaboration on how to better serve you or your child
- review by other students enrolled in clinic or Department of Communicative Disorders classes for teaching purposes.

If you do not want to be recorded or do not want your child to be recorded for these purposes, you must inform your clinician. You will be given a form to sign stating that recordings are not to be made. It will be placed in your client file.

Clinical sessions will be observed by authorized individuals who have undergone training regarding Speech and Hearing Center clients' right to confidentiality. Observation is required for students enrolled in various aspects of clinical training. It is also required as part of the teaching/learning process for student clinicians and clinical supervisors. It is sometimes recommended practice for parents to be engaged in the clinical process. Parents, with permission of the clinical supervisor, will at times observe their child's therapy.

The Notice also explains some of your rights under HIPAA, including but not limited to, your:

- right to ask that information about you not be disclosed to certain persons
- right to restrict disclosure of your clinical information to your health plan when you pay out of pocket in full for a healthcare item or clinical procedure
- right to ask that we communicate differently with you to ensure your privacy
- right to look at and get a copy of most of your clinical information in our records
- right to request that we correct clinical information in your record that is wrong or misleading
- right to be notified when a breach of your clinical information has occurred
- right to have us tell you to whom we have disclosed your clinical information
- right to make a complaint with our Privacy Officer or the Secretary of the U.S. Department of Health and Human Services.

I acknowledge that I have been given an opportunity to review this facility's Notice of Health Information Practices, that I understand what kind of information is contained in the Notice, that I am entitled to have my own personal copy of the Notice, and that a copy is available for me to have.

Client Name (Print): _____ Date: _____

Legal Representative Name (Print): _____

Signature: _____

Revised effective 9/23/2013

The University of Alabama
Speech and Hearing Center
Box 870242
Tuscaloosa, Alabama 35487-0242
Phone: 205-348-7131

ADULT CASE HISTORY FORM

Thank you for choosing The University of Alabama's Speech and Hearing Center to help you with your speech, language, and audiology needs. To help us prepare and conduct a thorough evaluation, we would like for you to fill out the following information. Please be as accurate as possible. The information given here will be treated confidentially.

Date: _____

I. General Information

Name of person completing this form: _____

Relationship to client: _____

Client's legal name: _____

Client's preferred name (if different): _____

Date of birth: _____ Age: _____

Address: _____
City State Zip

Home phone: _____ Cell phone: _____

Social Security # _____ Occupation: _____

Employer/School: _____

II. REFERRAL INFORMATION

Who referred you to this clinic? _____

Reason for referral: _____

III. EDUCATION HISTORY

Name of last school attended: _____

Highest degree earned: _____ Date: _____

IV. FAMILY HISTORY

Ethnicity (please circle) African American Hispanic American Indian

Caucasian Asian Multi-racial

Marital status (please circle) Widowed Divorced Married Separated

Name of spouse / significant other: _____

Children:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Emergency contact: _____
Name Relationship

Address of emergency contact: _____

Phone numbers of emergency contact (Home): _____ (Cell) _____

Is English your primary language? _____ Yes _____ No

If not, what is your primary language? _____

Is there any history of speech, language, or hearing difficulties in your family? If so, please describe:

_____

_____

_____

List the names of other people who live in your household: _____

_____

V. MEDICAL HISTORY

General Health: _____Excellent _____Good _____Fair _____Poor

Do you have a medical diagnosis? If so, specify: _____

Give the name of the physician who made the diagnosis: _____

Physician's address: _____

Physician's phone: _____ Fax: _____

Give the date of your diagnosis: _____

List all hospitalizations, major surgeries, and/or operations with dates: _____

_____

_____

_____

_____

_____

List all medications taken on a regular basis: _____

_____

Has your hearing been tested? _____ Yes _____ No By whom: _____

Results: _____

Has your vision been tested? _____ Yes _____ No By whom: _____

Are you sensitive to latex? _____ Yes _____ No

Do you wear dentures? _____ Yes _____ No

Do you have any eating or swallowing difficulties? _____ Yes _____ No

If yes, explain: _____

_____

Please check all conditions that apply to you:

____ Allergies
____ Colds/Flu/Sore Throat
____ Dizziness
____ Dental Problems
____ Laryngitis/Hoarseness
____ Epilepsy/Seizure Disorder
____ ADD/ADHD
____ Neurological Disorders
____ Frequent Headaches
____ Congenital Disorder
____ Vision Problems
____ Kidney Problems
____ Swallowing/Digestive Disorder
____ Heart Problems/Stroke
____ Cancer
____ Respiratory Difficulties (Asthma, TB, etc.)
____ Hearing Problems
____ Meningitis
____ Unusual Fatigue/Stress
____ Mental Illness
____ Thyroid Problems/Diabetes
____ Viruses (HIV, Herpes, Hepatitis)
____ Measles
____ Connective Tissue Disorder (Lupus, Arthritis)
____ Mumps
____ Chicken Pox
____ Mental Illness
____ Other: _____
____ Other: _____

Have you ever been seen by any of the following specialists? Check all that apply.

____ Neurologist
____ Psychiatrist
____ Audiologist
____ Ear, Nose, Throat Physician
____ Behavior Specialist
____ Physical Therapist
____ Occupational Therapist
____ Orthodontist
____ Nutritionist
____ Psychologist
____ Other: _____

VI. PRESENT COMMUNICATION STATUS

Please describe your present speech, language, and hearing, including any difficulties you are experiencing: _____

_____

_____

_____

Have you ever received a speech and language evaluation? _____ Yes _____ No

If yes, by whom and when? _____

_____

Results of previous evaluation: _____

_____

Have you ever had speech or language therapy? _____ Yes _____ No

If yes, by whom and when? _____

_____

When did the communication problem first begin? _____

Has the problem: _____ remained the same _____ gradually worsened _____ worsened quickly?

Describe the severity of the disorder. Does the severity vary? _____

_____

Overall, I would rate my communication as:

_____ Excellent _____ Good _____ Fair _____ Poor

Comments: _____

_____

What do you consider to be your greatest communication problem at this time?

_____

_____

Please list activities you enjoy: _____

_____

Do you have any other comments that may be helpful to us in planning your evaluation?

_____

_____