

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: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	Date of Birth ____/____/____
Name: Last _____	First _____ MI _____
Address _____	
City _____	State _____ Zip _____ Phone (____) _____
Employer _____	Work Phone (____) _____ SSN# _____

Section III	Insurance Information
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> 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 ADDITIONAL INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, COMPLETE THE FOLLOWING	
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> 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 _____

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: _____

**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 _____

**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: _____



THE UNIVERSITY OF ALABAMA
SPEECH AND HEARING CENTER
Box 870242
Tuscaloosa, Alabama 35487-0242
Phone: (205)348-7131

Children's Case History Form

(Please complete this information about your child and return the form to the above address. The information given here will be treated confidentially.)

Date _____

Child's Name _____ Sex _____

Child's Social Security Number _____ Birthdate _____

Address _____
Street or P. O. Box

City _____ State _____ Zip _____

Home Phone _____ Emergency Phone _____

Father's Name _____ Place of Employment _____

Mother's Name _____ Place of Employment _____

Public School Child Is Zoned To Attend _____

Child's Current School _____ Child's Doctor _____

List names and ages of persons in the home: _____

I. Who referred you to this Center? _____

Description of problem: _____

List names and agencies, clinics, teachers, or doctors from whom help has been sought:

II. Birth History

1. Health of mother during pregnancy: _____

2. Length of pregnancy: _____ months Length of labor: _____ hours

3. History of miscarriage? Yes _____ No _____

4. Abnormal circumstances during pregnancy or delivery: _____

5. Child's weight at birth: _____ lbs. _____ oz.

6. Health and/or feeding problems during first month? _____



III. Medical History

1. Has your child had a lot of ear infections? _____
2. List other major illnesses: _____
3. List serious injuries/surgeries: _____
4. Were there any after effects from illnesses? _____
5. Is child presently receiving medication? _____
6. Has child been diagnosed as having an exceptional problem? (e.g., Cerebral Palsy, Down's Syndrome, etc.) If so, what?

IV. Physical Development

1. List ages at which child: Sat alone: _____ Crawled: _____ Walked: _____
Fed self: _____ Toilet trained: _____ Dressed self: _____
2. Does child's physical development seem unusual? _____

V. Speech and Language Development

1. List ages at which child spoke: First words: _____ months Short phrases: _____ months
First sentences: _____ months
2. At what age was speech difficulty noted? _____ By whom? _____
3. Is child aware of problem? Yes _____ No _____
4. Is child's speech understood by others? _____
5. Does any other family member have speech/hearing problems? Yes _____ No _____
6. Does child have a hearing problem? Yes _____ No _____ Unsure _____
7. Is child slow in areas other than speech? Yes _____ No _____
8. Check any of the following which are problem areas:

- | | |
|---|------------------------------|
| _____ Incorrect pronunciation | _____ Talks very little |
| _____ Poor comprehension | _____ Talks too rapidly |
| _____ Slow in learning new words | _____ Talks too slowly |
| _____ Repeats or hesitates when talking | _____ Uses incorrect grammar |
| _____ Other? Describe _____ | |

VI. Behavior

Check any of the following that describe child's behavior:

- | | | |
|--------------------------|------------------------|--------------------------|
| _____ Shy | _____ Overly active | _____ Demands attention |
| _____ Overly talkative | _____ Withdrawn | _____ Cries easily |
| _____ Temper tantrums | _____ Short attention | _____ Unusual fears |
| _____ Nervous, sensitive | _____ Restless sleeper | _____ Behavioral problem |
| _____ Plays alone | _____ Sucks thumb | _____ Slow learner |

Person (Agency) Completing History Form

Address (Street, City, State, Zip)

Relationship to Child

Phone Number