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Adult Case History

Patient's Name: ______________________________________ Date: ____________________________________

Birthdate: ____________________ Age: ______

Gender: ☐ Male ☐ Female

Home Address: ____

Home Phone Number: _________________________ Cell Phone Number: ______________________________

Email Address(es): ____

Preferred method of communication: ☐ Home ☐ Cell ☐ Email

What is the reason for today's visit? ____

Diagnosis (if known): ____

Primary Care Physician: __________________________ Phone Number: _________________________________

Referral Source: _________________________________ Phone Number: _________________________________

How did you hear about Little Listeners? ____

Medical History

Have you had any of the following medical problems? Please check No, Past or Present to the right of the condition:

	No	Past	Present		No	Past	Present
Allergies				Hepatitis			
Asthma				High Fevers			
Cancer				Hospitalization			
Cerebral Palsy				Kidney Problems			
Chicken Pox				Mastoiditis			
Cleft Lip or Palate				Measles			
Concussion				Meningitis			
Cytomegalovirus (CMV)				Mumps			
Developmental Delay				Neurofibromatosis			
Diabetes				Noise Exposure			
Dizziness				Pneumonia			
Ear Infections				RespSyncitial Virus (RSV)			
Ear Surgery				Rubella			
Ear Tubes				Seizures			
Encephalitis				Sinusitis (Chronic)			
Frequent Colds				Tinnitus			
German Measles				Tuberculosis (TB)			
Head Trauma				Vision Problems			
Headaches (Severe)				Other: ________________			

If you answered Past or Present to any of the above, please describe and list approximate dates:

____

____

Have you been diagnosed with any of the following psychological or learning disorders? Please check Yes or No to the right of each condition:

	No	*Yes*		*No*	*Yes*		*No*	*Yes*
Anxiety			Bipolar Disorder			Obsessive/Compulsive		
Attention Deficit			Depression			Reading Disability		
Aspergers			Dyslexia			Sensory Integration		
Autism			Language Disorder			Visual Processing		
Behavior Disorder			Learning Disability			Other: ____________		

If you answered yes, please explain: ____

____

Please list any previous testing that has been performed:

Evaluation	*Approximate Date*	*Where/By Who*	*Brief Summary of Results*
Speech/Language			
Occupational Therapy			
Vision Therapy			
Psychological			
Neuro-Psychological			
Other: _______________			

Allergies or Dietary Restrictions: ____

Surgical History: ____

Have you had any scans, x-rays, MRI's or special tests? ☐ Yes ☐ No

If yes, please list and provide results: ____

Current Medications and Dosages (Supplements, OTC and Prescription):

____

Other Medical Concerns: ____

Educational/Occupational History

Current School/Occupation: ____

Highest Completed Grade Level/Degree: ____

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Do/Did you have any academic weaknesses:

None	Reading	Science	Social Studies
Math	Writing	Spelling	Other: ______________________________

Explain: ____

Are you currently enrolled in any therapy or academic tutoring? (include start dates and frequency)?

____

Learning style (check all that apply):

☐ Logical	☐ A planner	☐ Creative	☐ Spontaneous
☐ Analytical	☐ Good sense of time	☐ Intuitive	☐ No sense of time
☐ Sequential	☐ Good fine motor skills	☐ Scattered	☐ Good gross motor skills
☐ Detail oriented	☐ Rule oriented	☐ Disorganized	☐ Thinks outside of the box

Communication/Social Skills Difficulties

Communication difficulties (check all that apply): ☐ None

☐ Unclear speech ☐ A need for messages to be repeated ☐ Auditory memory weaknesses
☐ Localization difficulties ☐ Auditory sequencing weaknesses ☐ Misinterpretation of messages
☐ Attention weaknesses ☐ Frustration with communication ☐ (Other)________________________________
____

Social difficulties (check all that apply): ☐ None

☐ Impulsive ☐ Frustrations ☐ Distressed by loud sounds ☐ Difficulty sleeping
☐ Aggressive ☐ Shy ☐ Over-sensitivity to touch, light, or fabrics (circle all that apply)
☐ (other) ____

Hearing History

Do you have concerns about your hearing? ☐ Yes ☐ No If yes, please explain: ______________________________

Do you have a diagnosed hearing loss? ☐ Yes ☐ No If yes:

What type of hearing loss? Which ear(s)? ____

Wears amplification or an implant? ☐ Yes ☐ No If yes, type? ____

Do you have sound sensitivity? ☐ Yes ☐ No If yes, what type of reaction do you have to the offensive sound (fear, anger, pain, etc….)? __________________________

Family History

Do any immediate family members have any of the following conditions:

Condition	Yes	No		Yes	No
Anxiety			Hearing Loss from Birth		
Attention Deficit Disorder (ADD/ADHD)			Language Disorder		
Auditory Processing Disorder (APD)			Learning Disability		
Bipolar Disorder			Obsessive/Compulsive Disorder (OCD)		
Cognitive Deficits			Sensory Integration (SI) Disorder		
Depression			Other: ____________________		

If yes, please explain: ____

Is there anything else we need to know about you? ____

____

_____________________________________ ____ ______________

Print name Signature Date

FINANCIAL POLICY

Updated 04/26/2017

Little Listeners, LLC is out-of-network for all private insurance companies. Little Listeners, LLC charges the usual and customary rate for assessment and therapy services. ***Full payment is due at the time of service, regardless of out-of-network benefits.***

________parent/patient initials

Traditional Medicaid, Katie Beckett Medicaid, SSI Medicaid, and PeachState are the only insurances accepted at Little Listeners. Primary insurances will always be billed first and Medicaid will be billed secondary, unless it is the primary source of payment. Prior approvals are usually required for therapy services and some assessments. These approval requests require sharing of information with the primary care physician that can include the evaluation report, a Plan of Care and certain case history information to prove medical necessity. Services will be administered only *after* approval has been obtained - this is a Medicaid rule that Little Listeners can not change.

________parent/patient initials

I authorize Little Listeners, LLC to bill me directly for assessment and therapy services rendered to my child. I understand that I am responsible for payment for all services up front. If a payment plan has been arranged and payment has not been received within 30 days of receipt of the billing invoice, there will be a 10% late fee added each month until payment is received. Therapy services may be put on hold or terminated if there is a problem regarding payment. There is a $25 service fee for all returned checks. Little Listeners reserves the right to report payment negligence to an outside collections agency to recoup payment, if necessary.

________parent/patient initials

Please do not hesitate to contact us regarding questions of billing/payments. We are willing to work with each client to insure a balance between providing therapy services and addressing business issues or concerns.

I have read and understand the above insurance and billing policies.

Signed ____ Date _______________

Parent/ Legal Guardian Relationship

CONSENT FOR TREATMENT

I, ______________________ (caregiver's name), knowing that ________________________ (child's name) has a diagnosis requiring audiological testing and/or hearing therapy, voluntarily consent to such care for the aforementioned child by the therapist doing business for Little Listeners, LLC as may be beneficial in the professional judgment of this child's therapist. I consent to care and treatment that falls within the scope of practice as defined by the State of Georgia for each discipline. I understand that treatment will involve physical participation on the part of the patient which may involve risks of injury. You are responsible for making your therapist aware of any changes in your child's physical or mental status that may influence your child's plan of care. I acknowledge that no guarantee has been made to me as the result of evaluation and/or treatment. Little Listeners, LLC is a teaching facility and supervised students or volunteers may participate in your child's treatment session.

In my absence, I consent that________________________ (child's name) may receive therapy under the care of:

____.

(List all caregivers, teachers, daycare providers, etc. that may be present during therapy in your absence.)

Signed ____ Date _______________

Parent/Guardian Relationship

MEDIA RELEASE

I ___ do / ___ do not consent to the use of photos or videos of myself or my child to be used by Little Listeners, LLC on social media or in marketing materials for the purposes of business development and/or business marketing.

Signed ____Printed Name____________________ Date _______________

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND RELEASE OF INFORMATION FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

How should our staff address you (parent/guardian or patient if 18 or older)? ______________________________________

By signing, you acknowledge receipt of a copy of the currently effective Notice of Privacy Practices (NOPP) for Little Listeners. Your signature verifies that you have reviewed this NOPP and have been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. (A copy of this signed, dated document shall be as effective as the original.)

The policy at Little Listeners regarding **written** health information access, restricts that access to the individual (patient or guardian) signing this document. Reports and written communications with confidential information will be delivered via the email address provided in the case history and through our secure/encrypted email server to this single individual only. We ask that any other requests from other professionals involved in your (or your child's) care be handled between you and that professional directly with the electronic copy that we send directly to you. We will not be able to send personal written information via any other electronic format or to any other professionals without your specific and directed consent outside of this form. Consent can be granted either by handwritten or email communication and by specifically designating the written information to be shared and an email address or fax number to whom we may send the information securely.

The **verbal** information policy at Little Listeners regarding collaborative services for you or your child with Speech and Language Pathologists, Occupational Therapists, BCW Service Coordinators and Staff, Psychologists, Educators, Tutors, Physicians and or authorized business office personnel for those professionals is authorized by my signature below unless specifically excluded as the following:

____

By signing this form, you consent to being contacted by the phone numbers or email addresses provided in the case history regarding appointments, treatment, billing or specific health information.

If you prefer to opt out of updates from our clinic regarding special services, events, or fund raising efforts, please initial here. ________________

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Little Listeners is a non-discriminating company that will not refuse services based on cultural, religious or language differences. In the event of a language barrier, interpretation services will be provided to the client/family at our expense. We do, however reserve the right to refuse services if we feel as if a client/family is a threat to our staff, clients or other families within our facility, or if it is our judgment that our services may not be beneficial to you or your child.

It is your right to submit a complaint regarding our compliance with the HIPAA Omnibus Rule or State/Federal laws. You may request a form from us to complete or download a form at http://www.hhs.gov/hipaa/for-professionals/breach-notification/breach-reporting/index.html

___________________________________	__________________________________	________________
Please ***print*** name of Patient	Patient ***signature*** (if 18 years or older)	Date
___________________________________	__________________________________	________________
Please ***print*** name of Guardian	Guardian ***signature*** (if patient under 18)	Date

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Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment _____
- I could not communicate with the patient _____
- The patient refused to sign _____
- The patient was unable to sign because _____
- Other (please describe) _____ ____

Signature of Privacy Officer: __________________________________