LittleListeners
Helping young minds learn to listen

Pediatric Case History

Child's Full Name: _____ Date: _____
Nickname: _____ Birthdate: _____
Gender: ☐ Male ☐ Female Age: _____ ☐ Years ☐ Months
Parents Names: _____ Marital Status: _____
☐ Birth Parents ☐ Foster Parents ☐ Adoptive Parents ☐ Guardians
Parents Occupation(s): _____
Home Address: _____
Home Phone Number: _____ Cell Phone Number: _____
Email Address(es): _____
Preferred method of communication: ☐ Home ☐ Cell ☐ Email
Siblings Names and Ages: _____ ☐ Only Child
Who lives in the home with the child? _____
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? _____

Insurance Information (Out-of-Network)

Primary Insurance Company: _____ Person Insured: _____
Insurance Phone Number: _____ Policy Number: _____ Group Number: _____
Medicaid Number: _____ Effective Date: _____
Medicaid CMO Carrier: _____ CMO: ID Number: _____
(Traditional and PeachState only)

Birth History

Birth Hospital: _____ Gestational Age at Birth (length of pregnancy): _____ Weeks
Birth Weight: _____ ☐ Grams ☐ Pounds
Small for Gestational Age (SGA)? ☐ Yes ☐ No
Low birth weight? ☐ Yes ☐ No
Abnormal weight loss after birth? ☐ Yes ☐ No
Apgar scores normal? ☐ Yes ☐ No If not, what were the scores? _____
Prenatal difficulties? ☐ Yes ☐ No If yes, please describe: _____
Medications taken during pregnancy? ☐ Yes ☐ No
If yes, please list: _____
Delivery difficulties? ☐ Yes ☐ No If yes, please describe: _____

NICU (Special Care) stay after birth? Yes ☐ No ☐ If yes, how long? _____

Ventilation required? Yes ☐ No ☐ If yes, how long? _____

Any significant infections? Yes ☐ No ☐ If yes, please describe: _____

Medications given? Yes ☐ No ☐ If yes, please list: _____

Treatment for Jaundice? Yes ☐ No ☐ If yes, please describe: _____

Any scars or physical abnormalities? Yes ☐ No ☐ If yes, please describe: _____

Any congenital defects? Yes ☐ No ☐ If yes, please describe: _____

Any other significant birth history? _____

_____

Medical History

Has your child 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:

_____

_____

Known Allergies or Dietary Restrictions: _____

Surgical History: _____

Has your child 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: _____

_____

Hearing History

Was your child's hearing screened at birth? ☐ Yes ☐ No If yes, what were the results: _____

Do you have concerns about your child's hearing? ☐ Yes ☐ No If yes, please explain: _____

Does your child 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? _____

Preferential seating in the classroom? ☐ Yes ☐ No

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 your child? _____

_____

_____

_____

_____ _____

Print name of person completing this form Relationship to patient

_____ _____

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: _____