

DATE _____

SPEECH & HEARING

C E N T E R
S A V A N N A H

Adult Case History Form (Speech)

Please complete only those questions which apply to you.

Name _____ Birthdate _____ Age _____ M/F _____

Address _____

Street/P.O. Box _____ City _____ State _____ Zip Code _____ Race: _____ (United Way Stats)

Marital Status _____ Children? _____ If yes, how many? _____ Occupation _____

Spouse _____ Spouse's occupation _____

Home Phone _____ Work _____ Emergency _____

Referred By _____ Physician _____

A. Statement of the Problem

- Reason for referral _____
- When was the problem first noticed? _____
- Has the problem changed since first noticed? How? _____
If so, How? _____
- Situations in which the problem is worse _____
- What medical exams have you had for this problem? _____
By whom? _____ Where? _____
- List your social activities: _____
- List your hobbies and special interests: _____
- List any speech and/or hearing evaluations previously done: _____
- Speech and/or hearing therapy: _____
- Does the problem affect your job? _____ If yes, how? _____
- Is the problem constant or does it fluctuate? _____
- Do you know the cause of your problem? _____
- Is there any history of speech and hearing problems in the family? _____
- Do you have any physical disabilities not previously mentioned? _____
- List any doctors you are seeing: _____

B. Medical History

- How is your general health? _____
- Circle the illness or condition that applies to you: facial numbness blackouts diabetes heart disease
blurred vision high blood pressure arthritis other _____
- How often do the conditions affecting you occur? _____

C. ENT History

- Circle the illnesses or conditions that apply to you:
dizziness/vertigo ear infections allergies excessive ear wax surgery to the palate
ringing in the ears drainage from ears sinusitis hearing aids middle ear surgery
- If you have had surgery for any of the above what was/were the dates? _____
- How often do the conditions affecting you occur? _____
- If you are presently experiencing, or have had during the past year, any of the above conditions, please describe, and note any treatments you may have received. _____
- List any medication and dosages taken for any of the above disorders _____

Additional Comments: _____

The above information is correct. I hereby give SSHC my consent to treat: _____

Signature

SPEECH & HEARING CENTER SAVANNAH

1206 East 66th Street, Savannah, GA 31404 • Phone (912) 355-4601 • Fax (912) 355-7935

INSURANCE / PAYOR INFORMATION

Patient's name as appears on policy: _____

Patient's Date of Birth: _____ Sex: M/F

Contact (if child): _____ phone home: _____

Hours can be reached at home - _____ phone work/cell: _____

Responsible party/bill to: _____

PRIMARY INSURANCE/Medicare

COPAY: \$ _____ **Insurance Referral Number:** _____

Insured/Policyholder's Name: _____

(who has the insurance)

Insured's Address: _____

(if different from the client)

Date of Birth (Policyholder's): _____ Insurance Company: _____

Member ID Number: _____ Employer: _____

(need the individual's identification number to file)

Relationship to Patient: _____ Date Coverage Began: _____

SECONDARY INSURANCE

Insured/Policyholder's Name: _____

(who has the insurance)

Insured's Address: _____

(if different from the client)

Date of Birth (Policyholder's): _____ Insurance Company: _____

Member ID Number: _____ Employer: _____

(need the individual's identification number to file)

Relationship to Patient: _____ Date Coverage Began: _____

MEDICAID or PEACHCARE

Name as it appears on the card:

Last: _____ First: _____ Middle Initial: _____

Recipient ID Number: _____

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INSURANCE / PAYOR INFORMATION (Continued)

Please understand that the primary goal of the Center is to provide service to the public. We attempt to work with our clients regarding obligations for services whether payment may be through insurance, private pay, co-payments or other arrangements.

If payment is not received from an insurance company within 3 months from the date billed or if a denial is received from an insurance company, we will be required to call upon you for payment. Should you choose to appeal the denial and win, you will be reimbursed by the Center any money owed to you. A finance charge of 1% will accrue if payment is not received by the Center within 30 days of the date you are billed.

ASSIGNMENT OF BENEFITS

I hereby authorize payment by my insurance carrier of the benefits, otherwise payable to me, to be made directly to **Savannah Speech and Hearing Center** for their services.

I certify that the information given by me in applying for payment is correct. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for services to **Savannah Speech and Hearing Center**.

I authorize **Savannah Speech and Hearing Center** to release to all insurance companies and/or compensation carriers only such diagnostic, therapeutic, and financial information as may be necessary to determine benefits entitled and to process payment claims for health service that will be provided.

The insurance information given is an attempt to collect a debt. Any information obtained will be used for that purpose.

I understand and agree that I am financially responsible for charges not covered by assignment.

Date

Responsible Party or Patient

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Please Read Carefully and Initial

NAME: _____

_____ **CONSENT TO TREAT**

I give consent for myself and/or family member to receive the necessary evaluation and/or treatment by Savannah Speech and Hearing Center.

_____ **RELEASE/REQUEST**

Permission is given to Savannah Speech and Hearing Center to release and/or request information when necessary for the records of the above named individual.

_____ **PAYMENT RESPONSIBILITY**

All professional services rendered are charged to the client. Necessary insurance information will be filed for the client. However, the client is ultimately responsible for payment.

_____ **INSURANCE AUTHORIZATION/ASSIGNMENT**

I allow my insurance company to be billed and I request that payment of authorized benefits be made directly to Savannah Speech and Hearing Center for any services furnished to me by that provider. I authorize the release of any information to my insurance company required in the course of treatment that may be used to determine benefits payable under my insurance plan.

_____ **HEARING AIDS**

My insurance policy does not include a hearing aid benefit. Please do not bill my insurance company for hearing aids.

_____ **CONTACT INFORMATION**

I give my consent to leave messages on my voice mail.

I prefer to be contacted at the following number(s).

- _____ Work _____
- _____ Home _____
- _____ Cell _____
- _____ Other _____

Signature

Date

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AUTHORIZATION FORM Use and Disclosure of Protected Health Information

Client's Name _____ DOB _____

I authorize **Savannah Speech and Hearing Center** to use or disclose the above named client's protected health information.

1. Persons or groups authorized to receive this information:

2. Description of the information to be used or disclosed:

3. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations or other applicable state or federal laws.

4. I understand that I may revoke this authorization in writing at any time except to the extent that the action on this authorization has not already occurred.

5. Unless otherwise revoked, this authorization will expire one year from the date of signature or less than a year as indicated: _____

Client (or Representative) Signature

Date

Name of Personal Representative (Please Print)

Relationship to Client

I have received a copy of the Savannah Speech and Hearing Center's Privacy Practices Notice. _____(INITIALS)

Client records are kept for a period of eight (8) years and then destroyed if there has been no activity within that period of time.