SAVANNAH SPEECH & HEARING CENTER
Sound Principles. *Speak Volumes.*™

BACKGROUND INFORMATION: HEARING

Name: _____ DOB: _____ Age:_____ Gender: _____

Spouse: _____Contact Number: _____

Children (if they are caregivers):_____

Address: _____
Street/P.O. Box City State Zip Code

Contact Numbers: (H)_____(C)_____(W)_____

(Other)_____(Emergency:_____)_____

Email Address:_____

May we send you an **email** with reminders for future appointments? Yes☐ No☐ Preferred ☐
May we send you a **text** with reminders for future appointments? Yes☐ No☐ Preferred ☐
May we contact you via **US Mail** with news, updates and special promotions? Yes☐ No☐ Preferred ☐
May we contact you via **email** with news, updates and special promotions? Yes☐ No☐ Preferred ☐

PLEASE LIST YOUR MEDICATIONS (we are <u>REQUIRED</u> to know of them): _____

_____

_____

Do you think you have a hearing loss? Yes: ___ No: ___ If yes, cause and how long? _____

_____

Do family members or others think you have a hearing loss? Yes: ___ No: ___

Do you have problems hearing on the phone? Yes: ___ No: ___ If yes, which ear do you use on the phone? _____

Do others complain that you turn the TV up too loud? Yes: ___ No: ___

Do you struggle to understand speech in group situations or in the presence of background noise while others?
do not seem to have this problem? Yes: ___ No: ___

Is there a family history of hearing loss? Yes: ___ No: ___ If yes, describe: _____

Have you had any loud noise exposure? Work? Yes: ___ No: ___ Military? Yes: ___ No: ___ Hobby? Yes: ___ No: ___

Have you ever used a hearing aid? Yes: ___ No: ___ If yes, Which ear? Left ___ Right ___

If you do not now use a hearing aid, do you think you need one? Yes: ___ No: ___

Do family members or others think you need a hearing aid? Yes: ___ No: ___

Have you ever seen a physician who specializes in ear problems? Yes: ___ No: ___

If Yes, Who? _____When? _____

Did a physician refer you here? Yes: ___ No: ___ If yes, who? _____

Have you had any of the following? Ear infections? ___ Ear pain? ___ Ear fullness? ___

Dizziness? ___ Ear drainage? ___ Excessive ear wax? ___ Ear surgery? ___ Ear noises? ___

If Yes, please describe _____

When? _____ Which ear? left ___ right ____ both ____

Do you have: High Blood Pressure? ____ Diabetes? ____ Allergies? _____ If Yes, Describe: _____

Do you smoke? Yes:____No:____I smoked in the past but quit: Yes:_____No:____ How long: _____

Describe current general health status: _____

Your signature here grants permission to treat:

Sign: _____ Date: _____

Please Print Name: _____

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AUTHORIZATION FORM

Use and Disclosure of Protected Health Information

Patient Name:_____ **DOB:** _____

I authorize Savannah Speech and Hearing Center to use or disclose the above-named client's protected health information to the following listed people ONLY:

Doctors, Family members, Therapists, Schools, ETC. authorized to receive this information: ***YOU MUST LIST THE SPECIFIC NAMES OF EACH***

1. Physician that referred:_____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

1. 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.
2. 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.
3. This authorization will expire **ONE YEAR** from the date of signature. At this point, you will be required to update this form.

_____ _____

Patient (or Patient's Representative's) Signature **Date**

_____

Please Print Name

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Name:_____

INITIAL

_____ **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.

_____ **MEDICAL RECORD DISPOSAL**
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. I understand and acknowledge this.

_____ **SPEECH THERAPY TEXT REMINDERS** *SPEECH CLIENTS ONLY*
I give my consent to receive weekly SPEECH THERAPY appointment reminders via text message.

_____ _____
Signature of Patient or Responsible Party **Today's Date**

_____
Please Print your Name

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Patient Name: _____ **Date of Birth:** _____ **Gender:** _____

Please Circle Which Insurance Patient has: Amerigroup Peach State SSI Medicaid Care Source

ID#: _____

If Amerigroup, Care Source or Wellcare, please also provide Medicaid ID#: _____

●●

Primary Insurance Information

Policy Holder Name: _____ Date of Birth: _____

Insurance Company Name: _____ Employer: _____

Member ID # or (Social Security Number if Medicare/Tricare): _____

Member Service /Customer Service Phone #: _____ Group #: _____

Policy Holder Relation to Patient _____

●●

Secondary Insurance Information

Policy Holder Name: _____ Date of Birth: _____

Insurance Company Name: _____ Employer: _____

Member ID # or (Social Security Number if Medicare/Tricare): _____

Member Service /Customer Service Phone #: _____ Group #: _____

Policy Holder Relation to Patient _____

FLIP OVER FOR REQUIRED SIGNATURE TO TREAT

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

If payment is not received from your insurance company within 3 months from the date billed, or if a denial is received from your insurance company, we will be required to call upon you for total payment owed. Should you choose to appeal the denial and win, you will be reimbursed by Savannah Speech & Hearing 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 & 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 & Hearing Center**.

I authorize **Savannah Speech & Hearing Center** to release to all the 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 all charges *not covered* by assignment.

_____ _____

Responsible Party or Patient Signature **Date**

_____

Please PRINT the Above Name