

Hearing Information

1. Did your child pass the newborn hearing screening? _____
2. Do you feel that the child has a hearing loss? If yes, when and how was it noticed? _____

3. History of ear infections? If yes, how many and when was the last one? _____
4. What treatment or testing has child received regarding ears? _____
5. Do any family members have hearing problems? If yes, who: _____
6. Has the child ever been exposed to loud noise or explosion? _____
7. Does the child: complain about fullness or noises in the ear? _____
become confused with where sound is coming from? _____
watch the speaker's face closely for cues? _____
8. Does the child respond to the following: (check all that apply)
____ their name ___ loud noises ___ soft noises ___ verbal commands ___ vibrations

Additional Comments: _____

Signature for permission to treat: _____ **Date:** _____

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

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



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