UGA SPEECH AND HEARING CLINIC
The University of Georgia
Department of Communication Sciences and Special Education
706.542.4598 (office) 706.542.4574 (fax)

ADULT CASE HISTORY FORM (AUDIOLOGY)

Please complete this form. Attach copies of any additional information or reports that might assist us in our evaluation.

Name: _____ Birthdate: _____
First Middle Last

☐ Male ☐ Female ☐ Transgender ☐ Other: _____

Address: _____
Street/PO Box City State Zip Code

Home Phone: _____ Cell Phone: _____

Email: _____ Occupation: _____

1. May we contact you regarding your appointment at any of the phone numbers or addresses listed above? ☐ Yes ☐ No

If no, please state where we **may not** contact you: _____

Referred by _____

Primary Physician: _____ Telephone: _____

Emergency Contact: _____ Telephone: _____
Name Relationship to Client

2. Describe your chief complaint or reason for referral: _____
3. Have you had your hearing evaluated previously? ☐ Yes ☐ No
   If so, what were the results? _____
4. Do you have hearing loss? ☐ Yes ☐ No If so, which ear? ☐ Right ☐ Left ☐ Both
   When did it begin? _____ Has it become worse? ☐ Yes ☐ No
   Does it fluctuate or vary? ☐ Yes ☐ No
   What caused the hearing loss? _____
5. Is there a family history of hearing loss? ☐ Yes ☐ No
6. If so, who had hearing loss? _____
   What was the age it began? _____ What caused the hearing loss? _____
   Describe situations where you have a hard time understanding speech:_____
   _____
7. Have you had a history of loud noise exposure? ☐ Yes ☐ No
   Where were you exposed: ☐Work ☐Military ☐Hobbies (woodworking, shooting, motorcycles, etc.)
   How long were you exposed? _____ Did you use ear protection? ☐ Yes ☐ No
8. Do you hear noise, ringing, or buzzing in the ears? ☐ Yes ☐ No
9. If so, in which ear do you hear it? ☐ Left ☐ Right ☐ Both
   Describe how it sounds_____
10. Have you had dizziness or vertigo? ☐ Yes ☐ No If so, was it treated by a physician? ☐ Yes ☐ No
    If so, describe your symptoms:_____

11. Have you had surgery on your ears? ☐ Yes ☐ No If so, which ear? ☐ Left ☐ Right ☐ Both
12. What type of surgery did you have? _____

    When and where was your surgery? _____

    Who performed the surgery? _____
13. Have you had an ear injury? ☐ Yes ☐ No

    If so, describe_____
14. Have you had ear infections? ☐ Yes ☐ No If so, What ear? ☐ Left ☐ Right ☐ Both
15. What age did they begin? _____ How many have you had? _____

    When was the last infection? _____ Have you had drainage? ☐ Yes ☐ No

    What kind of treatment have you had? _____
16. Have you had a head injury? ☐ Yes ☐ No

    If so, describe_____
17. Please check any diseases you have had:

    ☐Measles ☐Mumps ☐Meningitis ☐Malaria

    ☐Diabetes ☐Kidney Infections ☐Circulatory problems

    ☐Other _____
18. Have you had a very high temperature? ☐ Yes ☐ No

    If so, how high was it? _____ How long did it last? _____
19. List any current medications:

Medication	Dosage	Frequency	Route (Mouth/Injection/Patch, etc.)	Reason for Medication

20. Which ear do you normally use on the phone? ☐ Right ☐ Left
21. Have you used a hearing aid previously? ☐ Yes ☐ No
22. If so, which ear? ☐ Left ☐ Right ☐ Both What type of aid? _____

    How long did you use it? _____ How did it benefit you?_____

_____ _____

Signature of person completing questionnaire **Relationship to Client** **Date**

The University of Georgia

THE UNIVERSITY OF GEORGIA
SPEECH AND HEARING CLINIC
PATIENT REGISTRATION FORM

Today's Date:	Birthdate:	Sex: ___M ___F ___ Transgender-Other	Primary Care Physician:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Marital status:

Social Security #:	Address: [Address/ P.O Box, City, ST ZIP Code]

Ethnicity: ☐ Asian ☐ Black/African American ☐ Caucasian/White ☐ Alaskan Native ☐ American Indian ☐ Hispanic/Latino ☐ Native Hawaiian or Other Pacific Islander ☐ Other_____ ☐ Decline to provide

Preferred Language: _____ **Do you require an interpreter?** ☐ No ☐ Yes **Type:** _____

Home Phone: **Cell Phone:** **Work Phone:** .

May we contact you at any of the above numbers and leave a message? ☐ Yes ☐ No

If no, Please let us know which numbers "NOT" to call: _____

By providing this telephone number, I understand, agree and give express consent that the UGA Speech and Hearing Clinic or anyone working on their behalf, including third party vendors, may contact me at the number provided by manually dialing the number or by using automated dialing technology.

Please note the only third-party vendor who may contact you on our behalf is a collection agency, if necessary to collect payment.

How did you find out about us:	Employer:	Employer phone no.:
___Physician ___Friend ___Yellow Pages ___Internet ___ Advertisement ___Insurance ___ Other: _____		

INSURANCE AND FINANCIAL RESPONSIBILITY INFORMATION

(Please have your insurance card available when you check in and give it to the receptionist.)

Person responsible for bill:	Birthdate:	Address (if different):	Home/Cell/Work phone no.:

Occupation:	Employer:	Employer address:	Employer phone no.:

Name of Primary Insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birthdate:	Group no.:	Policy no.:	Co-payment:

Patient's relationship to subscriber:

Name of Secondary Insurance (if applicable):	Subscriber's name	Relationship to Patient	Group no.:	Policy no.:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

Financial Policy

Please initial below to indicate that you have read and understand the Clinic's Financial Policies.
Discuss any concerns with the Clinic Accountant, Ms. Kathy Moss, at 706-542-3895.

Initials	
	Information: You agree to provide your correct name, current and correct address, phone numbers, insurance information, Social Security number, driver's license or state issued picture identification at the time of registration or as requested by the UGA Speech and Hearing Clinic. These are needed for verification of benefits and to reduce the possibility of identity fraud. These measures are taken to protect you.
	Appointments: Our office will make every attempt to schedule appointments that are convenient for you. Minors and patients requiring assistance must be accompanied by a parent/guardian or caregiver unless special arrangements have been made with the office. We require a minimum of a 24-hour notice for cancellations as a courtesy to other patients seeking services. We will bill $25.00 for appointments missed without a 24-hour notice (this amount cannot be billed to third-party payers). A pattern of missed appointments without notice may result in discharge from the clinic. (Continued on the reverse side)

Initials	
	Medical records: The medical chart is the property of the UGA Speech and Hearing Clinic; however, copies of your pertinent medical information are available upon request. The Clinic charges a fee for a copy of the record according to those published annually by the State of Georgia Comptroller's Office. This fee schedule is available upon request.
	Financial Responsibility: You are responsible for all charges related to services you have received in our clinic. When the patient is a minor or under guardianship, the parent or guardian accompanying the patient assumes the responsibility.
	Payment methods: We accept cash, checks, MASTERCARD, DISCOVER, VISA and AMERICAN EXPRESS credit cards. **Returned checks:** If your check is returned from the bank, you are responsible for all related fees with a minimum charge of $35.00.
	Insurance Claims: If applicable, our office will submit insurance claims. Insurance companies do not pay all fees and may exclude certain services and diagnosis form coverage. **It is your responsibility to understand your insurance plan.** Insurance payment is not guaranteed even if you have confirmation verbally or in writing from your carrier. An insurance company's response to a claim is the final decision in determining coverage. All copayments are due at the time services are received. All deductibles, coinsurance, or non-covered services are to be paid within 30 days of the first statement sent to the responsible party. If it is not possible for you to pay the complete balance within 30 days, please contact our office at 706-542-3895. We will help find the right payment option for your needs. Financial assistance is available for clients who apply and meet requirements. **Slow Insurance Response:** You understand that if your insurance company takes more than 60 days to respond to your claim, we shall consider your services to be your financial responsibility. It will be your responsibility to seek reimbursement from your insurance carrier. **Usual and customary**: Some insurance plans may indicate that our fees are above the *usual and customary*. As a result your plan may reduce our fee to an *allowed amount* before calculating payment. Unless we have specifically contracted with the carrier, it is expected that you will be responsible for the full fee charged**.**
	Statement Policy: Our office sends patient statements each month. Payment is due upon receipt of the statement. You understand that if we file an insurance claim for services, the sending of a statement may be delayed until your insurance responds. Such a delay should not take more than 60 days. You understand that such a delay does not alter our policy of patient financial responsibility, and you will be responsible for all service fees. I agree to pay the UGA Speech and Hearing Clinic for services received, in accordance with the rates and terms of the Clinic, including my portion of charges that were **1.** Not paid by insurance carriers, worker's compensation, or any third pary, and/or **2.** Not covered by adjusted fee or scholarships approved by the Clinic
	Collections policy: Accounts more than 90 days old are subject to transfer to an outside collection agency. These agencies charge for their services. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33.3% of the debt, and all costs and expenses, including reasonable attorney's fees, we incur in such collection efforts.
	Physician Referrals/Prescriptions: We must have an original prescription from a physician if the patient: 1. Is a Medicare or Medicaid recipient, when required for a covered service. 2. Has Medicare benefits and is referred by a physician for audiology testing to help the physician diagnose or manage the patient. (Note: Medicare does not cover testing to determine the need for or type of hearing aid) 3. Receives insurance benefits that require a referral/prescription for services to be reimbursed; or 4. Has a medical condition that our clinic policy requires a referral/prescription before services are provided. **"You will not be seen for your appointment if we do not have a written referral/prescription when required."**
	Medicare and Medicaid have restrictions on services provided by students; please request additional information if you are a beneficiary of either. We are required to give Medicare and Medicaid beneficiaries an Advanced Beneficiary Notice of Non-coverage (ABN) when we expect a denial or partial payment for an item or service.

☐ **I do not have health insurance coverage**; **therefore, I understand that I am responsible for payment to the UGA Speech and Hearing Clinic.**

Signature: _____ Date: _____

☐ **As provided for under the HITECH Act, I request that my medical information not be disclosed to my insurance carrier to file a claim for payment. I understand that I am responsible for payment in full to the UGA Speech & Hearing Clinic for the services I do not want disclosed. Services "not" to be disclosed include:** _____

(Discuss this request with our accountant)

Signature _____ Date _____

☐ **I authorize my insurance benefits be paid directly to the UGA Speech and Hearing Clinic. In the event your insurer sends a payment for a claim from the UGA Speech and Hearing Clinic directly to you, you agree to forward that payment to us in fulfillment of any amounts due. I understand that I am financially responsible for any balance.**

I authorize The UGA Speech and Hearing Clinic to release any information required to process my claims.

Signature: _____ Date: _____

I have read and understand all the terms of this policy and by my initials and my signature below, I attest that I fully understand each item and agree to the terms above. The above information is true to the best of my knowledge.

Signature: _____ Date: _____

THE UNIVERSITY OF GEORGIA
College of Education
The Speech and Hearing Clinic

UGA Speech and Hearing Clinic
Communication Sciences and Disorders Program
593 Aderhold Hall, Athens, GA 30602
706.542.4598

CONSENT FOR SPEECH AND HEARING CLINIC SERVICES

Client's Name: _____ **Client's DOB:** _____

Parent/Guardian's Name (if client is a minor): _____

I, _____, hereby authorize The University of Georgia Speech and Hearing Clinic audiologists, speech-language pathologists, or students under the direct supervision of audiologists or speech-language pathologists, to conduct requested clinical services at the University of Georgia Speech and Hearing Clinic. I understand that services will be completed by a state-licensed and nationally certified audiologist or speech-language pathologist or by a student under direct supervision.

I agree that for educational purposes, clinic sessions may be observed by UGA Communication Sciences and Disorders faculty and student clinicians. I agree that the UGA Speech and Hearing Clinic personnel may audio record, videotape, or store sessions in an electronic format. Recordings of sessions may be used for educational purposes only. I also authorize the use of clinical case discussions for teaching purposes. I agree that all information will be held in the strictest confidence legally possible. I understand my clinician must be in compliance with child abuse reporting laws and court mandated rulings regarding release of confidential information.

I agree that permission must be granted in writing before I may take photographs of clinic sessions. I understand that audio or video recordings of sessions are not permitted to be made by clients, caregivers, or other individuals who are non-clinic personnel.

AUTHORIZATION FOR CONSENT:

❒ I fully understand and accept the terms of this *Consent for Speech and Hearing Clinic Services*.

Client/Authorized Representative Signature* | Relationship (if applicable) | Date

AUTHORIZATION FOR DATA COLLECTION:

❒ I agree to allow testing or treatment data to be included in the ongoing pool of clinic research data, understanding that this material will not contain any identifying data, but rather that all data will be coded by consecutive subject number.

Client/Authorized Representative Signature* | Relationship (if applicable) | Date

ACKNOWLEDGEMENT OF PRIVACY NOTICE:

❒ I acknowledge that I received the UGA Speech and Hearing Clinic *Notice of Privacy Practices*. A copy of the *Notice of Privacy Practices* will be provided when requested in paper or electronic format.

Client/Authorized Representative Signature* | Relationship (if applicable) | Date

❒ A good faith effort was made to obtain from the client a written acknowledgment of his/her receipt of the Notice of Privacy Practices. The acknowledgement was not obtained because: ☐ Client refused to sign ☐ Client was unable to sign or initial because _____ ☐ Other (describe): _____

Witness / Office Staff Signature | Date

CONSENT TO CORRESPOND ELECTRONICALLY:

Email does not always provide a secure means of communication. There is a risk that any protected health information contained in email may be disclosed to, or intercepted by, unauthorized third parties. More secure means of correspondence are always available, if you do not wish to transmit information via email. By completing this form, I understand and am willing to accept the risks involved with insecure email communication of my protected health information. Clinic personnel may email me at _____@_____regarding my services and care.

Client/Authorized Representative Signature* | Relationship (if applicable) | Date

***If patient is a minor (under the age of 18), each section must be signed by a parent or legal guardian.**

UGA Speech & Hearing Clinic
593 Aderhold Hall, Athens, GA 30602
706.542.4598 Office

Directions

From Atlanta Highway/ Broad Street
-Head Northeast on Atlanta Highway/ US-78 (towards downtown Athens)
-Turn right on South Thomas Street which will turn into East Campus Road
-Turn Right on Green Street (red light after crossing the rail road tracks)
-Client parking is the 2nd entrance to the left

From US-129, Jefferson
-Head South on US-129, which turns into Prince Avenue and then W Dougherty Street
-Turn right on North Thomas Street which turns into East Campus Road
-Turn Right on Green Street (red light after crossing the rail road tracks)
-Client parking is the 2nd entrance to the left

From North Atlanta
-Take I-85 N to GA-316 E (to Athens)
-After the Oconee Connector Intersection
    -Merge to the right for GA 10 Loop South (toward Hartwell/Lexington & UGA)
-Continue on GA 10 Loop for 5 miles to Exit #7 College Station Road
-Turn left on to College Station Road
-Turn right at the 3rd red light, on East Campus Road (immediately after the rail road tracks)
-Turn left at the 2nd red light, on Green Street
-Client parking is the 2nd entrance to the left

From South Atlanta (Airport)
-Take I-285 E to I-20 E
-Take I-20 E to GA 138 (Exit 82 Conyers) turn left onto GA 138
-Merge onto US-78 E/GA-138
-Merge on to 316 E
-After the Oconee Connector Intersection
    -Merge to the right for GA 10 Loop South (toward Hartwell/Lexington & UGA)
-Continue on GA 10 Loop for 5 miles to Exit #7 College Station Road
-Turn left on to College Station Road
-Turn right at the 3rd red light, on East Campus Road (immediately after the rail road tracks)
-Turn left at the 2nd red light, on Green Street
-Client parking is the 2nd entrance to the left

Enter the College of Education Building/Aderhold Hall
Take the elevators to the 5th floor, our waiting room is to the right (room 593)

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