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

QUESTIONNAIRE FOR ADULTS

Please complete this form as completely as possible. Attach copies of any additional information or reports that might assist us in our evaluation. Please be assured that any information you provide will be handled in a confidential and secure manner.

IDENTIFICATION

Name:_____ Birthdate: _____
First Middle Last

☐ Male ☐ Female ☐ Transgender ☐ Other: _____

Address:_____
Street/PO Box City State

Zip Code:_____ County:_____ Birth Country (if other than US):_____

Telephone: Home:_____ Work:_____ Cell:_____

Email: _____ Last grade completed/highest degree or certificate earned: _____

Occupation: _____ Employer: _____

If retired, previous occupation: _____

Emergency phone: _____ Contact person:_____
Relationship to client

May we contact you about your appointment at the above addresses/telephone/email? ☐ Yes ☐ No. If no, please state where we may not contact you: _____

Person or agency that referred you to our program: _____

Reason for referral/concerns: _____

_____

What is your opinion of the cause for the problem? _____

When was the problem first noticed and by whom? _____

Describe any changes since it began: _____

What has been done about it?_____

FAMILY / PERSONAL INFORMATION

Marital status: ☐Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

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

Spouse's name (if applicable): _____

Spouse's occupation: _____ Employer: _____

How has your problem affected your family? _____

If other than English, what language(s) do you understand? _____ Speak? _____

What is your native language? _____ What is your dominant language?_____

Name:_____ **Birthdate:** _____ **Date:** _____

List all people now living in your home:

Name	Relationship	Age

List the names and ages of your children (if not listed above), if applicable:

Name	Relationship	Age

List any members of your immediate family with a history of speech, language, reading (dyslexia), academic, motor, psychological, or behavioral, problems: _____

Please describe any problems listed for family members:_____

Does anyone in your family have hearing problems? □ No □ Yes: Describe: _____

What are your hobbies or interests? _____

MEDICAL/HEALTH INFORMATION

Height:_____ Weight: _____

Primary physician: _____ Telephone: _____

List any limitations or precautions due to medical reasons: _____

List any current medications (please attach list, if additional space is needed):

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

Do you have any allergies to: Medications (list): _____ Foods: □ Peanuts □ Other foods: _____

Environmental allergies: □ Dust □ Molds □ Pets □ Pollen □ Other: _____

Have you had any allergic reactions to any of the following:

Balloons? ☐ Yes* ☐ No Surgery or dental work? ☐ Yes* ☐ No

Latex/rubber gloves? ☐ Yes* ☐ No Other rubber or latex products? ☐ Yes* ☐ No

Does the client have Spina Bifida/Myelomeningocele? □ Yes* □ No

**Use non-latex products, if "yes"*

Name:_____ **Birthdate:** _____ **Date:** _____

Describe any surgeries or hospitalizations:

Date	Hospital Location	Reason

Have you had a hearing test? ☐ No ☐ Yes	If yes, when?	Where?	Results?
Have you had a vision test? ☐ No ☐ Yes	If yes, when?	Where?	Results?

List other physicians that currently provide you with medical care:

Specialty	Name (First, Last)	Address/Location

Please check and describe any conditions that apply to your history. Please state age when occurred and frequency, if applicable:

☐Anemia	☐Arthritis	☐Asthma
☐Bleeding Disorders	☐Breathing Problems	☐Bronchitis
☐Cancer Type:	☐Cerebral Hemorrhage/Stroke	☐Chicken Pox
☐Chronic Liver Disease	☐Colds (frequent)	☐Connective Tissue Disease
☐Concussion	☐Congestive Heart Failure	☐Convulsions/Seizures Type:
☐COPD	☐Craniofacial Problems (describe):	
☐Diabetes (Non-insulin dependent)	☐Diabetes (Insulin dependent)	☐Dizziness/Vertigo
☐Ear Infections	☐Depression	☐Emphysema
☐Encephalitis	☐Head/Brain Injury (describe)	
☐Headaches	☐Heart Problems:	☐Hepatitis / Type:
☐Hernia Type:	☐HIV/AIDS	☐Hypertension
☐Laryngectomy	☐Leukemia	☐Lymphoma
☐Learning Problems	☐Lupus	☐Measles
☐Memory Loss/Dementia/Confusion (describe):		
☐Intestinal Problems	☐Meningitis	☐Multiple Sclerosis
☐Meniere's Disease	☐Otosclerosis	☐Mumps
☐Paralysis (describe type/location):		
☐Pneumonia	☐Parkinson's Polio	☐Polio
☐Primary Progressive Aphasia	☐Rheumatic Fever	☐Reflux/Heartburn/GERD
☐Scarlet Fever	☐Schizophrenia	☐Sickle Cell Anemia
☐Sinus Infections	☐Skin Problems: ☐ Dermatitis ☐ Eczema ☐ Other:	
☐Snoring	☐Speech Problems	☐Stomach Problems/Ulcer
☐Spina Bifida/Myelomeningocele	☐Tumor (brain or other):	☐Tracheotomy
☐Tinnitus	☐Tonsillitis	☐Urinary Tract Problems (congenital)
☐Vocal Polyps	☐Vocal Nodules	☐Voice: Hoarseness
☐Voice / Resonance Problems - Describe:		☐Whooping cough
☐Other:		

Name:_____ **Birthdate:** _____ **Date:** _____

Have you had a brain scan (MRI, CT, PET)? ☐ No ☐ Yes: When: _____

Please provide any additional information to describe current problems or health concerns: _____

_____

If your communication problem was the result of an accident or illness, what was your level of independence before your illness or injury? _____

Has your communication problem affected your work or school? ☐ No ☐ Yes: Describe: _____

Have you been exposed to loud noises? ☐ No ☐ Yes: Describe: _____

Do you have any hearing problems? ☐ No ☐ Yes: Describe: _____

If so, do you wear or have you worn a hearing aid? ☐ No ☐ Yes: Describe: _____

Do you wear glasses? ☐ No ☐ Yes: ☐ Reading ☐ Distance

Do you have any problems reading? ☐ No ☐ Yes: Describe: _____

Describe any dental or orthodontic problems: _____

Do you have dentures? ☐ No ☐ Yes: ☐ Upper ☐ Lower

Describe any eating or swallowing concerns or problems: _____

Do you cough or choke when eating or drinking? ☐ No ☐ Yes: Describe: _____

Are you ☐ Right handed? ☐ Left handed?

Do you have any problems writing? ☐ No ☐ Yes: Describe: _____

Do you have any problems walking? ☐ No ☐ Yes: Describe: _____

Please list any previous evaluations or therapy for speech, hearing, physical, occupational, psychological, or behavioral problems:

Date(s)	Type Service/Evaluation/Therapy	Agency	Location

Please have copies of previous evaluations sent to our Clinic before your evaluation appointment, if possible, or bring with you.

Please add additional comments that may be helpful in our evaluation: _____

_____

_____

What are your expectations from this evaluation? _____

_____

_____

Signature of Person Completing Questionnaire **Relationship** **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.**