AUDIOLOGY ASSOCIATES OF ARLINGTON

3132 Matlock Road, STE 303, Arlington, Texas 76015 (817) 472-7720

Child Paperwork (*Under 18 years old*)

DATE: _____

REFERRED BY: _____ PRIMARY CARE PHYSICIAN: _____

NAME: FIRST_____MIDDLE_____LAST_____

BY WHAT NAME WOULD YOU LIKE TO BE ADDRESSED? _____

BIRTHDATE_____AGE_____SEX_____

ADDRESS: _____CITY_____STATE_____ZIP_____

PREFERRED PHONE (_____) _____ ☐Home ☐Cell ☐ DO NOT LEAVE A DETAILED MESSAGE

SECONDARY PHONE (_____) _____ ☐Home ☐Cell ☐ DO NOT LEAVE A DETAILED MESSAGE

EMAIL_____ ☐ CHECK IF EMAIL IS PREFERRED METHOD OF CONTACT

If you would prefer **NOT** to receive educational newsletters via mail or email please check here ☐

DOES CHILD LIVE WITH: BOTH PARENTS / MOTHER / FATHER / JOINT CUSTODY / OTHER

ADDRESS IF DIFFERENT FROM CHILDS: _____

MOTHER_____ DATE OF BIRTH_____ EMPLOYER _____

FATHER_____ DATE OF BIRTH _____ EMPLOYER_____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

POLICY HOLDER: _____ BIRTHDATE: _____ RELATIONSHIP: _____

SECONDARY INSURANCE: _____

POLICY HOLDER: _____ BIRTHDATE: _____ RELATIONSHIP: _____

PATIENT AUTHORIZATION OF DISCLOSURE

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means. The patient may revoke or change this authorization at any time with a written request.

Please indicate any other persons with which you would like us to be able to communicate health, insurance, and/or financial information relating to your hearing health care:

Relationship: _____ Name: _____ Phone # _____

Relationship: _____ Name: _____ Phone # _____

Guardian Signature: _____ Date: _____

Name any medications the patient is taking now: _____

Any additional medical and/or developmental conditions or concerns: _____

List any complications during pregnancy or delivery: _____

Has the patient had ear surgery? ☐ No ☐ Yes ear infections? ☐ No ☐ Yes ear drainage? ☐ No ☐ Yes

Has an ear Doctor been consulted? ☐ No ☐ Yes, doctor seen? _____

Are speech & language developing at an age appropriate rate? _____

Has a speech-language pathologist been consulted? ☐ No ☐ Yes, who? _____

Do you suspect your child has a hearing problem? ☐ No ☐ Yes, how long? _____

Has the child's hearing been tested before? ☐ No ☐ Yes

If yes, when were the first and last tests? _____ Where? _____

What findings and/or recommendations were discussed? _____

Did your child pass his/her newborn hearing screen? ☐ No ☐ Yes

Does the patient consistently and appropriately respond to speech or directions? ☐ No ☐ Yes

Does the patient consistently turn their head to find sound source? ☐ No ☐ Yes

Which do you think is the better ear? ☐ Right ☐ Left

What is believed to be the cause of the hearing loss? _____

Did the hearing loss happen gradually or sudden? _____ Does hearing seem to fluctuate? ☐ No ☐ Yes

What reaction is there to loud sounds? _____

List other family members that have a hearing loss_____

Is there a ringing or other noise in the ears? ☐ No ☐ Yes

Any dizziness or imbalance? ☐ No ☐ Yes, describe_____

Where is there trouble hearing? TV_____ Groups_____ School_____ Noise_____ Large rooms_____

Does the patient hear but have difficulty understanding? ☐ No ☐ Yes

Does the patient rely on others to translate for him/her when he/she cannot understand? ☐ No ☐ Yes

Has the patient tried or used a hearing aid? ☐ No ☐ Yes **If yes**, complete the following:

Ears fitted? ☐ right ☐ left Type(s) _____ Brand(s) _____
In the ear / Behind the ear Brand name(s)

Serial number(s) Right: _____ Left: _____ When/Where purchased_____

FOR OFFICE USE ONLY:

_____

_____

_____

_____

AUDIOLOGY ASSOCIATES OF ARLINGTON

PLEASE SIGN YOUR INITIALS BY EACH STATEMENT TO CONFIRM YOUR AGREEMENT AND SIGN AND DATE AT THE BOTTOM.

CONSENT FOR AUDIOLOGICAL SERVICES

_____ I consent to receive Audiological services at Audiology Associates of Arlington. This consent encompasses Audiological procedures including, but not limited to, diagnostic testing, and rehabilitative treatment. I understand that this consent form will be valid and remain in effect as long as I receive Audiological care at Audiology Associates of Arlington.

PAYMENT & INSURANCE BENEFITS

_____ I understand and agree that **regardless of my insurance status**, I am ultimately responsible for the balance of my account for professional services or purchases rendered.

_____ **If providing insurance,** I authorize release of medical information for my insurance claims to my insurance company and its utilization review. This potentially may include information about psychiatric conditions, alcohol and drug use, sickle cell anemia, or aids, depending upon the contents of my records. **NOTE: Without this release it is not possible to file insurance claims.**

RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ I have been made available a copy of Audiology Associates of Arlington's Notice of Patient Privacy Practices.

Patient or Guardian Signature: _____ Date: _____

For office use only:

GOOD-FAITH EFFORTS

Patient Name: _____

Date: _____

The patient was provided with a copy of Audiology Associates of Arlington's Notice of Privacy Practices on the date noted above. A good-faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

☐ Patient refused to sign.
☐ Patient was unable to sign because:

_____

☐ Patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.
☐ Other reason (describe below):

_____

Signature of Employee Completing Form: _____

Original to be maintained in patient's permanent medical record.