Innovative Hearing Services, Inc.

Cindy Bazell Wilson, MA CCC-A/FAAA
Audiologist

Patient Information

Patient's Name_____
Address_____
City_____ State_____ Zip_____
Home Phone_____ Work Phone_____
Email Address_____
Soc Sec #_____ Date of Birth_____ Sex: Female___ Male___

Marital Status: Married___ Single___ Other___
Student Status: Full Time___ Part Time___ None___
Employment Status: Full Time___ Part Time___ None___

Primary Physician_____

Primary Insurance Information (If the patient is also the insured, enter 'SAME' for name and address)

Insured's Name_____
Address_____
City_____ State_____ Zip_____
Home Phone_____ Work Phone_____
Patient Relation to Insured: Self___ Spouse___ Child___ Other___
Insured Date of Birth_____ Insured Sex: Female___ Male___
Insured Employment Status: Full Time___ Part Time___ Retired___ None___
Insured Employer_____
Insurance Company Name_____
Subscriber ID Number_____ Group Number_____

Primary Insurance Information (If the patient is also the insured, enter 'SAME' for name and address)

Insured's Name_____
Address_____
City_____ State_____ Zip_____
Home Phone_____ Work Phone_____
Patient Relation to Insured: Self___ Spouse___ Child___ Other___
Insured Date of Birth_____ Insured Sex: Female___ Male___
Insured Employment Status: Full Time___ Part Time___ Retired___ None___
Insured Employer_____
Insurance Company Name_____
Subscriber ID Number_____ Group Number_____

Signature_____ Date_____

2766 West Eleven Mile Rd., Suite 8 ● Berkley, MI 48072 ● 248-544-0560 ● 248-544-7480 Fax
www.innovativehearingservices.com ● e-mail: hearbetter1@yahoo.com

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PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of, your Notice of Privacy Practices. This privacy notice contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I wish to be contacted in the following matter (circle all that apply)

Leave a message with detailed information YES or NO

Leave a message with call back number only YES or NO

Mail office updates (e.g. newsletter) YES or NO

Printed Patient Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

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Patient Name:_____

PERMISSION TO RELEASE RECORDS

We provide you with important information about your hearing. We feel is it important for your physician to have this information for your medical records. By signing this form you are providing us with permission to send a copy to your physician. This release will be in effect until we receive written notice from you requesting that we no longer forward this information.

Patient / Guardian Signature: _____ Date: _____

Physician or Referring Agency: _____

PERMISION TO OBTAIN RECORDS

In order to provide you with the best service possible, we may need to contact your previous audiologist or hearing aid dispenser, your physician or hearing aid manufacturer for information regarding your hearing, hearing aid, warranty, etc. This release will be in effect until we receive written notice from your requesting that we no longer obtain this information from this source.

Patient / Guardian Signature: _____ Date: _____

Name: _____

Address: _____ Tel: _____

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Please answer the following questions to the best of your ability. Use the back if more room is needed for your answer.

Child's Name: _____ Birth Date: _____ Sex: M / F

Parent's Names: _____

Address: _____ City: _____ State/Zip: _____

Fax #: _____ Email Address: _____

Siblings' Names and Ages: _____

Physician: _____

ENT: _____ Neurologist: _____

Person completing the questionnaire: _____

How did you hear about AIT? _____

Name of child's school: _____

Type of school program: _____

Services provided: _____

Child's diagnosis:
Autistic ____ Attention Deficit Disorder ____ Learning Disabled ____ Speech & Language Disorder ____ Central Auditory Processing Disorder ____ Pervasive Development Disorder ____ Other/None ____

Do sounds appear to be painful or bothersome to your child? _____

Does your child appear to have trouble hearing? _____

Does your child have ventilation tubes in one or both ears? _____

At what age(s) did your child have the most ear problems? _____

Does your child have allergies? _____ If yes, to what? _____

What are the child's symptoms/reactions? _____

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Has your child had speech and language problems? _____

If yes, describe: _____

_____

Does your child appear to learn better visually or auditorily? _____

How does your child interact in group situations? _____

_____

Have any of the following been expressed as a concern? If yes, by whom?

___ Speech and language
___ Following directions
___ Learning in general
___ interaction with others
___ disruptive behavior
___ depression
___ spelling
___ writing
___ fine motor skills
___ listening
___ ability to communicate needs
___ memory
___ attention span
___ isolation
___ reading
___ math skills
___ balance
___ gross motor skills

What are your child's strengths? _____

_____

What are your areas of greatest concern? _____

_____

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FISHER'S AUDITORY PROBLEMS CHECKLIST

Name: _____ Age: _____ Date: _____

Please place a check mark before each item that is considered to be a concern by the observer.

___ 1. Has a history of hearing loss.
___ 2. Has a history of ear infection(s).
___ 3. Does not pay attention (listen) to instruction 50% or more of the time.
___ 4. Does not listen carefully to directions - often necessary to repeat instructions.
___ 5. Says "Huh?" and "What?" at least five or more times per day.
___ 6. Cannot attend to auditory stimuli for more than a few seconds.
___ 7. Has short attention span.

(If this item is checked also check the most appropriate time frame)

___ 0-2 minutes ___ 5-15 minutes
___ 2-5 minutes ___ 15-30 minutes

___ 8. Daydreams - attention drifts - not with it at times.
___ 9. Is easily distracted by background sound(s).
___10. Has difficulty with phonics.
___11. Experiences problems with sound discrimination.
___12. Forgets what is said in a few minutes.
___13. Does not remember simple routine things from day to day.
___14. Displays problems recalling what was heard last week, month, year.
___15. Has difficulty recalling a sequence that has been heard.
___16. Experiences difficulty following auditory directions.
___17. Frequently misunderstands what is said.
___18. Does not comprehend many words - verbal concepts for age/grade level.
___19. Learns poorly through the auditory channel.
___20. Has a language problem (morphology, syntax, vocabulary, phonology).
___21. Has an articulation (phonology) problem.
___22. Cannot always relate what is heard to what is seen.
___23. Lacks motivation to learn.
___24. Displays slow or delayed response to verbal stimuli.
___25. Demonstrates below average performance in one or more academic areas.

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