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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ASSIGNMENT OF INSURANCE BENEFITS

Patients with insurance please read and sign below:

Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims or accept responsibility for negotiating claims with your insurance company. As a courtesy we will be happy to help you determine the coverage you have available.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans to Innovative Hearing Services, Inc. A photocopy of my insurance card and a copy of my driver's license are to be considered as valid as an original.

I am financially responsible for all charges whether or not paid by the above insurance. I hereby authorize Innovative Hearing Services to release all information necessary to secure the payment. If insurance pays only a portion of the bill or fails to make payment to Innovative Hearing Services, Inc. within 90 days, I will be responsible for payment of the balance in full at that time. It is my responsibility to provide Innovative Hearing Services, Inc. with a medical clearance from an Ear, Nose & Throat (ENT) doctor prior my appointment.

Patient's Name Signature Date

MEDICARE PATIENTS:

I request payment of authorized Medicare benefits to be made to Innovative Hearing Services, Inc. for any services rendered. I authorize any holder of personal medical information to be released to the Health Care Financing Administration and its agents. I also authorize the release of any information needed to determine these benefits or related services to pay the claim. If there are other insurance carriers, my signature authorizes releasing of information. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible for only the deductible, coinsurance and the non-covered services. Coinsurance and the deductible are based upon the charge determined by the Medicare carrier. Medicare only covers testing. If I would like Innovative Hearing Services to bill Medicare for my hearing test a prescription is required from my physician prior to my appointment. This can also be faxed by my doctor's office to Innovative Hearing Services at 248 544-7480. Medicare does not cover hearing aids.

Patient's Name 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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Date completed ________

Child's full name: ____Date of Birth:___________

School: _________________ Grade: ____ Program: ____________ District:________________
Person completing this form: ________________ Relation to child: _______________________

Father's Name:	______________________	Mother's Name:	______________________
Address:	______________________	Address:	______________________
City:	______________________	City:	______________________
Home Phone:	______________________	Home Phone:	______________________
Cell Phone:	______________________	Cell Phone:	______________________
Work Phone:	______________________	Work Phone:	______________________
Email Address:	______________________	Email Address:	______________________
Date of Birth:	______________________	Date of Birth:	______________________
Occupation:	______________________	Occupation:	______________________

With whom does the child live? ____
# of Siblings and Ages? ____
If adopted, at what age? ______ Location Adopted From: ______________________________
Does your child have an educational or medical diagnosis? ______________________________

MEDICAL INFORMATION:

Family Doctor/Pediatrician: _______________________________ Phone: __________________
Illnesses: ____
History of Ear Infections: ____
Seizures: ____
Surgeries: ____
Current Medications: ____
Allergies: ____
Is your child presently under the care of any doctor other than your pediatrician? Y/N
Name of Doctor: _____________________________ Reason: _____________________________
Name of Doctor: _____________________________ Reason: _____________________________

Date of last vision screening: _________________ Results: ______________________________
Recommendations:____
____
Date of last hearing screening: ________________ Results: ______________________________
Recommendations:____
____

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EDUCATIONAL HISTORY:

Previous Schools: ____

____

Is your child receiving resource assistance at school? _________________________

Describe the concerns you have about your child: _______________________________

____

____

What do you see as your child's strengths? _____________________________________

____

____

THERAPY HISTORY:

Please list any therapy the child has received (when, where and duration of treatment): ______

____

____

____

BIRTH HISTORY:

Pregnancy:

Age of mother during pregnancy: _____ General health of mother:____________________

Length of pregnancy: ______ Complications: ______________________________________

Medications taken during pregnancy: ____

Delivery:

Duration of labor: ______ Type of delivery: _____________

Any difficulties during delivery: ____

Birth weight: ______ Apgar score: ______ Oxygen? Y / N

Intensive care (NICU) needed? Y / N Length of hospitalization: _____________

Respiratory complications after birth? Y / N

Describe your infant: ____

Breast fed? Y / N Bottle fed? Y / N Did baby suck readily? Y / N Tube fed? Y /N

Sleeping patterns: ____

DEVELOPMENTAL HISTORY:

At what age did your child reach the following motor milestones?

Roll	___________	Reach for objects	___________
Sit	___________	Feed self	___________
Pull to stand	___________	Drink from a cup	___________
Crawl	___________	Use a straw	___________
Walk	___________	Use a writing utensil	___________
Ride a tricycle	___________	Cut with scissors	___________
Ride a bike	___________	Swim	___________
Toilet train	___________		

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LANGUAGE SKILLS:

When did your child begin to:

Babble __________ Use First Word __________ Combine two words __________

Use complete sentences containing four words or more __________

Did speech begin and then stop? (If so, at what age?) Y / N ______

Is your child's ability to understand and use language equal? If not, which is better? ________

SELF CARE SKILLS: (If not independent, what help is needed for the following)

Dressing: ____________________

Toilet: ____________________

Bathing: ____________________

Hygiene: ____________________

Sleeping: ____________________

Feeding: ____________________

SOCIAL HISTORY:

How does your child play with other children (cooperative, leader, loner, aggressive, picked on, etc.)

____

____

____

Does your child make friends easily? _______ Does your child need to be in control? ________

Describe any concerns about your child's social skills: ____________________

____

____

____

Is your child difficult to discipline? (please explain) ____________________

In a few words describe your child as a(n):

Infant: ____________________

Toddler: ____________________

Currently: ____________________

Is there any other information that has not been covered that may be helpful? ______________

____

____

____

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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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APS- BUFFALO MODEL QUESTIONNAIRE

Child's Name ______________________________________ Date _________

Please place a check mark if this may be a problem area for your child.

___ 1. Auditory Processing
___ 2. Auditory-visual integration
___ 3. Speech (articulation)
___ 4. Ear infections / fluid early years
___ 5. Learning disability
___ 6. Mentally challenged
___ 7. Autism or related problem
___ 8. ADHD/ADD
___ 9. Anxiety (e.g., new situations)
___10. Behavior
___11. Psychological
___12. Dyslexia
___13. Head injury
___14. Responds quickly
___15. Speaks quickly
___16. Responds slowly / delayed
___17. Speaks slowly
___18. Sometimes very long delays
___19. Frequently interrupts
___20. Hypersensitive to noise
___21. Hypersensitive to touch
___22. Understanding language
___23. Using language
___24. Following oral directions
___25. Understand oral directions
___26. Oral reading
___27. Remembering oral directions
___28. Keeping things in order
___29. Messy / tends to lose things
___30. Reading comprehension
___31. Reading / spelling severe
___32. Distracted by noise
___33. Understanding speech in noise
___34. Extreme poor handwriting
___35. Memory long-term
___36. Memory recent or short-term
___37. Attention
___38. Coordination
___39. Allergies
___40. Phonics
___41. Spelling
___42. Math
___43. Sequencing
___44. Hearing
___45. Foreign language learning
___46. Noisy child / makes noises
___47. Severe visual perception
___48. Eye contact with speak

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