CHAMPLAIN VALLEY AUDIOLOGY

Child Information Form

Date:_____

Patient Name:_____ Male/Female DOB: _____

Phone (H)_____ E-Mail Address _____

Address_____

Primary Care Physician_____

Father's Name_____ DOB:_____Contact #_____

Mother's Name_____ DOB:_____Contact #_____

Name of person filling out form other than parent_____

Relationship to child_____

1. Who referred your child to this hearing test and why?_____

   _____

   _____

2. What concerns do you have about your child's hearing?_____

   _____

   _____

3. Has your child ever had a hearing test? Yes No

   If so, when, where, and what were the results?_____

   _____

4. Does anyone in the family (siblings, aunts, grandparents, etc.) have a handicap or problem with language, learning, hearing, speech, etc.?_____

   _____

5. Has your child's doctor ever said your child has fluid behind the eardrums? Yes No
6. Has your child ever had an ear infection lasting three months or more? Yes No
7. Has your child ever had tubes placed in the ears? Yes No
8. Has your child had a known ear infection in the last three months? Yes No
9. Has speech and language development been normal? Yes No Unsure
10. Has your child ever received a speech and language evaluation? Yes No Unsure
11. Does your child currently receive speech and/or language therapy? Yes No

    Name of speech-language pathologist_____

Over-→

Please list the medication your child is currently taking.

1._____ Purpose_____

2._____ Purpose_____

3._____ Purpose_____

12. Does the patient have allergies to any substance (including chemicals)? _____

    If so, what?_____

13. Does your child receive any extra services (eg. PT, OT, Special Education)? Yes No

    If so, what?_____

14. If your child attends school, has he or she repeated any grades? Yes No
15. Has your child been diagnosed with any disorder or condition? Yes No
16. Do you believe that your child has any learning problems? Yes No
17. Were any of the following present after your child's birth, or during the first 2 months of life? Please check all that apply:
    - ○ Head trauma, especially basal skull/temporal bone fracture requiring hospitalization
    - ○ Was in neonatal intensive care for more than 5 days, or any of the following regardless of length of stay: ECMO, assisted ventilation, exposure to ototoxic medications (gentamycin or tobramycin) or loop diuretics (furosemide/lasix) and hyperbilirubinemia requiring exchange transfusion
    - ○ Infections at birth or in utero, including CMV, herpes, rubella, syphilis, and taxoplasmosis
    - ○ Craniofacial anomalies, including those involving the pinna, ear canal, ear tags, ear pits and temporal bone anomalies
    - ○ Physical findings, such as white forelock, associated with a syndrome known to include a sensorineural or permanent conductive hearing loss
    - ○ Family history of permanent childhood hearing loss
    - ○ Neurodegenerative disorders, such as Hunter syndrome, or sensory motor neuropathies, such as Friedreich ataxia and Charcot-Marie-Tooth syndrome
    - ○ Culture-positive postnatal infections associated with sensorineural hearing loss, including confirmed bacterial and viral (especially herpes viruses and varicella) meningitis
    - ○ Syndromes associated with hearing loss or progressive or late-onset hearing loss, such as neurofibromatosis, osteopetrosis, and Usher syndrome. Other frequently identified syndromes include Waardenburg, Alport, Pendred, and Jervell and Lange-Nielson
    - ○ Chemotherapy
18. Is there any other information that you would like us to know?_____

    _____

    _____

Thank you for choosing Champlain Valley Audiology, PLLC. We will be happy to answer any questions regarding the child's evaluation.

CHAMPLAIN VALLEY AUDIOLOGY

Office Financial Policy

Payment is due at the time of service. All copays and co-Insurances must be paid at the time of service, failure to do so will result in the rescheduling of your appointment. We accept cash, personal checks, Visa, Master Card, Discover, and American Express.

- We do also offer financing through Care Credit, please see our office manager for more information.

Insurance Verification is not a guarantee of coverage. Your insurance policy is a contract between you and your insurance company. At Champlain Valley Audiology, we are happy to verify your benefits prior to your appointment and require all insurance information to be given to office staff at the time of scheduling. We will do our best to maximize all benefits you are entitled to.

Cancellation Policy and Continuation of Care: Maintaining a relationship with our patients is our top priority and consistency of care is key to maintaining proper hearing health. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. We request and appreciate a notification at least **24 hours** in advance to cancel an appointment. We reserve the right to dismiss any patient from our practice who misses or cancels, without 24 hour notice, three or more consecutive appointments. Appointment changes must be made directly through our office, a message may be left on the machine when the office is not open.

I have been giving the opportunity to ask questions regarding this policy. I have read an understand the financial policy.

Signature:_____ Date: _____

Consent for Release of Information

Name of Patient:_____DOB:_____

(please initial all 3 boxes)

☐ **I HEREBY AUTHORIZE** *Champlain Valley Audiology* to release any and all information contained in the medical record of the above listed patient to any third party payer for whom I may seek payment or reimbursement for expenses related to my office visit. I also authorize *Champlain Valley Audiology* to use Claims Connection to process such claims.

☐ **I HEREBY ASSIGN** and set over all insurance benefits to which I am entitled and which are otherwise payable to me to *Champlain Valley Audiology*.

☐ **I HEREBY AUTHORIZE** *Champlain Valley Audi*ology, having treated me, to release information to other health care facilities or physicians involved in my care.

Please list authorized persons with whom we may discuss your Protected Health Information in addition to custodial parents and legal guardians:

1. _____

2. _____

3. _____

4. _____

_____ _____

Signature of Patient Other Authorized Signature

_____ _____

_____
Print Name of Client

_____ _____
Print Name of Personal Representative (if applicable) Description of Personal Representative's Authority

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
(Notice of Privacy Practices Version Number 1.0, Dated June 18, 2008)

By signing below, I acknowledge that I have been provided a copy of this *Notice of Privacy Practices* and have therefore been advised of how certain health information about me may be used and disclosed by Champlain Valley Audiology and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information and genetic information.

Consent for Treatment, Payment and Health Care Operations

In providing service to you, we create and store health information that identifies you. We understand that this information about you and your health is personal, and we are committed to protecting the privacy of this information. We must obtain your written consent before we treat you, obtain payment or provide services at Champlain Valley Audiology. ***Please read carefully the information below before signing this form.***

Scope of Consent: By signing this consent form, you will permit Champlain Valley Audiology and its staff to use your protected health information for treatment, payment, and normal business operations. You also permit our staff to share your information with other persons or organizations outside this practice that perform payment activities and business operations jointly with the practice.

Notice of Privacy Practices: We have a *Notice of Privacy Practices* that describes these uses and disclosures in detail and we encourage you to read it. We want you to know, however, that the *Notice of Privacy Practices* is subject to change. If it is changed, you may obtain a copy of the revised notice by asking for a copy at your next visit or by calling our office.

Restricting Use and Disclosure: You have the right to ask us to restrict the uses or disclosures of your protected health information. Champlain Valley Audiology is not required to agree to this restriction, but if it does, it will be bound by its agreement unless the information is needed to provide you with emergency treatment or comply with the law.

Revoking consent: You have the right to revoke this consent at any time, except to the extent that Champlain Valley Audiology has provided you with treatment, the practice will be permitted to use or disclose your protected health information to bill for that treatment. To revoke this consent, please contact our office.

I have read this consent and understand it. I consent to the use and disclosure of my health information for the purposes of treatment, payment, and health care operations.

I also consent to be contacted via phone and email (if email address has been provided).

_____ _____
Signature of Client or Personal Representative Date