Hyman
Hearing &
Speech Center
Leading the way to better communication since 1978

Joy Hyman Goldberg, M.A., CCC-SLP, Director
Karen Moellman, M.A., CCC-A
Jamie Gilts, .Ed., CCC-SLP
Lee Zelina, M.A., CCC-SLP
Pamela Weisenburger, M.A., CCC-SLP
Brenda Maran, Office Manager

Patient Information

Patients Name: _____
DOB: _____ **Age:** _____
Male _____ **Female:** ____
Address: _____
City: _____
State: _____
Zip code: _____

Primary Insurance Information

Primary Insurance: _____
Policy Holder: _____
Policy Holder's Date of Birth: _____
Policy Holder's Address: _____
Policy Holder's City, State and Zip Code: _____
Phone Number: _____

Secondary Insurance Information

Secondary Insurance: _____
Policy Holder: _____
Policy Holder's Date of Birth: _____
Policy Holder's Address: _____
Policy Holder's City, State and Zip Code: _____
Phone Number: _____

5950 Airport Hwy., Ste 17, Toledo, Oh 43615-Office-419.865.7500/Fax-419865.8532
www.hymanhearingspeechctr.com or email-hymanhearspeak@aol.com

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Authorization of Information

Date: _____

Patients Name: _____

Patient's Date of Birth: _____ _____

I, _____ _____ hereby authorize the following person(s) to bring my child in for medical treatment. I also allow them to make any medical decisions that are in the best interest of my child. I understand that this person in required to bring a picture ID with them to the visit along with my child's insurance card(s) and any co-payment that is due at the time of visit. Without a picture ID the child will NOT be seen. Failure to present insurance card(s) and any co-payments due may result in the child not being seen as scheduled. In the event of emergency, Hyman Hearing and Speech Center assumes we have implied consent since you sent child with someone not on list. I can be reached at _____-_____-_____for any questions and/or concerns. Person authorized to bring the child to medical appointments:

1) _____ Relationship _____

2) _____ Relationship _____

3) _____ Relationship _____

This authorization will remain active, unless a written statement is received by the parent/guardian to revoke an authorized person.

X _____

Parent/Guardian Signed and Date

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INSURANCE INFORMATION

NEED TO KNOW AND UNDERSTAND:

- **Co-payment:** A fixed amount that you pay for certain health services before the health plan pays, due at each visit at the time of service.

- **Coinsurance:** The portion of the charge that is not paid by the health plan (usually a fixed percent of each amount paid by the plan)

- **Deductible:** An amount that must be paid before the health plan pays for covered services. If you have co-payment for office visits or coinsurance or deductible amounts that you must pay before your health plan pays for these services, our office will charge you these amounts. We value your time and want to make the most of each appointment for your child. This is why we will address any problem that needs attention.

- Our office does not want you to be surprised by a bill but must always bill your health plan based on the actual services performed. **YOU ARE RESPONSBILE FOR KNOWING YOUR INSURANCE COVERAGE.** You always have the right to refuse services by informing the office staff BEFORE the service is performed. Once your insurance has been billed for services performed, we are contracted with them to collect patient due amounts from you and cannot make exceptions. We hope this helps you understand our office policy and your insurance coverage. It is our pleasure to help.

X _____

Parent/Guardian Signature and Date

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Insurance Policy

1. All insurance recipients must present their current insurance card)s) and State ID at the time of service. If you do not have your insurance card you will be considered self-pay patient.
2. Patient/Guarantor will be responsible for all charges incurred if no insurance card is present. It is your responsibility to know what is covered and what is not.
3. Please notify our office at 419.865.7500 if there are any changes in your insurance coverage or change of carriers.

This is to certify that I the undersigned, voluntarily consent to the administration of the practice of diagnostic procedure/imaging/photography and medical treatment by providers, authorized agents and employees of the practice as may, in their professional judgment deemed necessary or beneficial. Unless otherwise specified, all healthcare providers may obtain additional consents for individual procedures. I (we) acknowledge that no guarantees have been made to me (us) as to the effect of such examination or treatment. I understand that the insurance benefits are provided directly for the patient/guarantor and I, the undersigned, further agree and understand that I am directly responsible for all financial obligations to Hyman Hearing and Speech Center. If for any reason I fail to meet my financial obligations to Hyman Hearing and Speech Center to seek a collection agency or court action as a means of collection, I understand that I will be responsible for the balance due on my collections plus all fees related to the collections.

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS I hereby consent to the use or disclosure of my individually identifiable health information ("protected health information") by Hyman Hearing and Speech Center in order to carry out treatment, payment, or health care operations. I understand that I can review Hyman Hearing and Speech Center Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and I have the right to review such Notice prior to signing this Consent Form. Hyman Hearing and Speech Center reserves for itself the right to change the term for its Notice of Privacy Practices for Protected Health Information at any time. If Hyman Hearing and Speech Center does change the terms of Notice of Privacy of Practices for Protected Health Information, I may obtain a copy of the revised notice by calling the office and requesting a revised copy be sent in the mail or asking at the time of my next appointment. I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. Hyman Hearing and Speech Center is not required to agree to such requested restriction(s); however, if Hyman Hearing and Speech Center does agree to my requested restriction(s), such restriction(s) are then binding on The Pediatric Center. At all times, I retain the right to revoke this consent in writing to Hyman Hearing and Speech Center except to the extent that action has already been taken. Hyman Hearing and Speech Center may refuse to treat Patient if he/she (or authorized representative) does not sign this Consent Form (except to the extent Hyman Hearing and Speech Center is required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consent, Hyman Hearing and Speech Center has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that Hyman Hearing and Speech Center is required by law to treat individuals). I fully understand and have read the INSURANCE POLICY and the CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS and agree to abide by these policies.

X _____

Signature of parent/legal representative

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OFFICE POLICY AND PROCEDURES

Effective November 1st, 2019 the following policies have been implemented:

1. At the time of check-in at EVERY visit, you will be required to provide your insurance card and State ID. All insurance will be verified upon arrival. All copays and deductibles will be due at time of service
2. If you are a new patient, please arrive ½ hour before scheduled appointment time to complete the registration process.
3. If you are a new patient please make sure to have insurance card, State ID, Referral from either family doctor or pediatrician. If you do not have referral at time of appointment, you will either have to call the doctor's office and have them fax it to us at 419.865.8532 or need to reschedule appointment.
4. There is a $25.00 service fee for any returned checks. In addition, ALL expenses incurred to recover outstanding balances will be payable immediately, (including but not limited to collection agency fees and legal fees).
5. To better serve all of our patients, if you miss 1 appointment without calling or contacting us before 9:00 a.m. prior to appointment you will be charged $50.00 unless you reschedule that appointment and keep it. We will not call you to remind you that you missed; if you miss 2 more after that appointment without calling or contacting us before 9:00 a.m. prior to appointment you will be dismissed from this practice. This is not intended to cause any inconvenience to you, but to make these appointments available to patients who need appointments.

MEDICAL RECORDS RELEASE POLICY AND PROCEDURES

1. A medical records release must be filled out or requested on our patient portal by the parent or legal guardian of the patient PRIOR to the copying of any medical records. Please request or fill out one release per patient.
2. All school, sports, daycare physicals or similar forms will be completed within 2 business days at no charge. I have read and understand the **OFFICE POLICIES & PROCEDURES and MEDICAL RECORDS RELASE POLICY AND PROCEDURES.**

X _____

Parent/Guardian Signature and Date

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THIS MUST BE SIGNED AND RETURNED BEFORE YOUR CHILD CAN BE SEEN.
PLEASE BRING THIS TO THEIR FIRST APPOINTMENT!!

Practice Policies and Precautions During the COVID-19 Health Crisis

During this challenging time, when people are concerned about health due to the COVID-19 coronavirus outbreak, everyone must make their own risk assessment before proceeding with services. We are providing the information below to detail precautions we are taking to help guide your decision-making, but no one can really provide a completely risk-free environment.

To minimize in person payment, we can bill the credit card we have on file or if you wish to pay by check you are welcome to do so.

For the time being, the waiting room and bathroom will be closed to clients, so we will meet your child at the front door when it is time for their appointment. Upon meeting your child at the door, the therapist will take your child's temperature with a no touch, sensor thermometer. We will then require that clients wash hands thoroughly and therapists will do the same. Hand sanitizer and hand washing will be available during the session if needed. It is strongly recommended that clients wash hands upon leaving. While we will try to provide hand sanitizer, the availability of this cannot be guaranteed, so please bring some with you, if you like, but there will be plenty of soap.

In addition to the regular weekly professional cleaning of the office, we will be using CDC approved disinfectant methods before, during and after each session, as well as commonly touched surfaces such as desks, door handles and toys.

It is imperative that you are on time for your appointment. If you are more than a few minutes late, you will not be seen. Please make sure your child has used a bathroom shortly before appointment. No food is permitted to be brought to therapy so if your child has a snack while waiting please ensure they are finished prior to appointment time.

We are opening slowly with only two speech therapists working at time with staggered appointments to limit exposure and adhere to social distancing guidelines. Clients will be encouraged to wear masks and we will have child friendly masks available as appropriate. Therapists will be wearing masks with a clear panel to allow mouth visibility as appropriate. Social distancing guidelines will be followed to every extent possible during sessions and as an added protection, each therapy room will have available a 3' x 2.5' plexiglass partition with a pass through, to allow for the exchange of therapy materials.

It is critical to cancel an appointment if you or we have had any COVID-19 symptoms (such as dry cough, fever, shortness of breath, etc.) , have been in recent contact with a person diagnosed with COVID-19, or are otherwise sick. There will be no cancellation fee. In the case of exposure, we will wait at least 14 days before rescheduling. In the case of illness or a positive test for the virus, we will discuss what is needed, in terms of when it is safe to proceed, in consideration of current CDC guidelines.

For those in a group at high-risk for severe illness from COVID-19, or who have regular contact with someone in this group, currently defined as including but not limited to:

- those 65 years or older
- those who are immune compromised (cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications)
- people of all ages with underlying medical conditions, particularly if not well controlled, including chronic lung disease, moderate to severe asthma, serious heart conditions, severe obesity, diabetes, liver disease, chronic kidney disease undergoing dialysis

You are encouraged to delay services and obtain medical guidance from your physician. Your safety and well-being are our top priority.

PRIVACY NOTICE:

Please be aware that in the event that a therapist, any of our clients, office colleagues or visitor to the office are suspected of having COVID-19, the Health Department, CDC, or other officials may require disclosure or names and contact information. Normally, privacy rules prohibit disclosure of client information, but during outbreaks of illness where other people may be in danger, we may be obligated to provide this information to authorities to prevent community spread of disease. If you are uncomfortable with this possibility, we will have to cancel sessions until this COVID-19 outbreak has resolved.

I understand and agree to all the above notice and change in privacy procedures.

Patient name: _____

Patient signature: _____

Date: _____

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Pediatric Audiology Case History

To be completed by a parent or guardian

IDENTIFYING INFORMATION:

Today's Date: _____

Client's Name (Please Print)

Last, First, MI: _____

Birthdate: (month day year) _____/_____/_____ Age: _____

Gender: Female: _____ Male: _____

_____

The following questions are designed to help us evaluate your child's auditory system. Please answer them as accurately and completely as possible. If a question does not apply please write NA.

1. What is the primary reason for this appointment?

_____

_____

2. Do you feel your child's hearing is stable or does it fluctuate? _____

3. Has he/she been diagnosed with any medical conditions or developmental disabilities?

□Yes □ No If yes, please list diagnoses

_____

4. Does your child have a history of ear infections? □Yes □ No

If yes, how many ear infections have they had? _____

5. Have tubes been placed in your child's ears or has your child had other ear surgeries?

□Yes □ No

If yes, how many sets of tubes or what type of ear surgery? _____

6. To your knowledge did your child pass their newborn hearing screening? □Yes □ No

7. Has anyone in your child's family been diagnosed with hearing loss before 30 years of age?
□Yes □ No
If yes, who in the family has a hearing loss and at what age? _____

8. Has your child's hearing been tested before by an audiologist? □Yes □ No
If yes when was the last hearing test?_____Where?_____
Results: _____

9. Does your child currently wear hearing aids? □Yes □ No
If yes, how old are the current aid(s)? _____

MEDICAL HISTORY:

Was any of the following present in your child's life? Please check all that apply

□Measles
□Meningitis
□Mumps
□ Allergies
□ Neonatal intensive care for more than 5 days
□ Hyperbilirubinemia (jaundice)
□ Anoxia (oxygen deprivation)
□ Ototoxic medications (e.g. gentamycin, aminoglycoside, loop diuretics)
□ Infections at birth or in utero (e.g. CMV, herpes, rubella, syphilis, taxoplasmosis)
□ Postnatal infections associated with hearing loss (e.g. herpes, meningitis)
□ Syndromes associated with hearing loss (e.g. neurofibromatosis, Usher syndrome, Waardenburg syndrome, CHARGE, Down syndrome)

ACADEMIC DEVELOPMENT:

1. Is your child in school? □Yes □ No Grade _____
2. How would you describe your child's academic performance/progress?
_____
3. In what area is your child having difficulty? _____
4. Where is your child seated in the classroom? _____
5. Does your child currently receive support services (including speech language therapy, occupational therapy, physical therapy, special education)? □Yes □ No

If yes please explain type of services _____

6. Does your child seem to have any of the following issues, please check all that applies?

- ☐ Problems following directions
- ☐ Distracted by background noise
- ☐ Oral and written expression problems
- ☐ Remembering what they hear
- ☐ Difficulty with multi-step directions
- ☐ Learning to read