HSDC
Hearing, Speech & Deaf Center

Artz Communication Center
1625 19th Ave Seattle, WA 98122
206.323.5770 www.hsdc.org

# Audiology Child History Form

Child's Name: _____ Date of Birth: _____

Person completing this form/Relationship: _____

I. **Describe your major concern(s) about your child**: _____

_____

_____

_____

II. **What specific questions would you like to have answered**: _____

_____

_____

_____

III. **Prenatal and Birth History:**

1. During this pregnancy, did the mother experience any unusual illness, accident or condition, such as German measles, high blood pressure, bleeding, Rh incompatibility? If so, please describe: _____

_____

_____

2. During the pregnancy did the mother (*please check)*
   - ☐ Take medication? ☐ Smoke?
   - ☐ Drink alcohol? ☐ Take recreational drugs?

   Please describe: _____

   _____

3. Were there any complications with delivery? ☐ Yes ☐ No

   Please describe: _____

   _____

4. Birth weight:_____ How many weeks gestation at time of delivery: _____

5. Condition of baby at birth: _____

   Jaundiced? ☐ Yes ☐ No If yes, how was it treated? _____

6. Any time spent in the neonatal intensive care unit (NICU)? ☐ Yes ☐ No

   Length of stay: _____

   Reason: _____

   _____

   _____

HSDC
Hearing, Speech & Deaf Center

Artz Communication Center
1625 19th Ave Seattle, WA 98122
206.323.5770 www.hsdc.org

## IV. Medical History

1. Is the child in good health at this time? _____
2. Other medical conditions or diagnoses? _____
   _____
3. Does the child have a suspected or known hearing loss? ☐ Yes ☐ No
4. Does anyone in the child's biological family have a hearing loss? ☐ Yes ☐ No
   Please list: _____
5. Does/did your child suffer from any of the following? *(please check)*

   ☐ Frequent colds ☐ Seasonal allergies

   ☐ Ear infections ☐ History of fevers

   When was the most recent? _____ How was it treated?: _____
6. Has your child had a hearing test before? ☐ Yes ☐ No
   If yes, where? _____ When? _____
   What were the results? _____
7. Does your child wear hearing aids? ☐ Yes ☐ No If yes, how long? _____
8. Has your child seen a physician for an ear examination? ☐ Yes ☐ No
   When? _____ Results: _____
   Physician: _____ Clinic/Hospital _____
9. When was your child's most recent physical examination? _____
   Physician: _____ Clinic/Hospital _____

## V. School History

1. Is your child now in school, preschool, and/or day care? ☐ Yes ☐ No
2. Name of the current school: _____
3. Hours and days of attendance per week: _____

## VI. Special Health Considerations/Precautions

HSDC Staff will review charts and pay special attention to any disclosed healthcare needs (e.g., seizures, pacemaker, diabetes, etc.) Please describe any special precautions or procedures we may need to know in case of emergency:

_____
_____
_____

## VII. Emergency Contact:

Name: _____ Relationship: _____

Phone: _____ Email: _____

HSDC
Hearing, Speech & Deaf Center

Artz Communication Center
1625 19th Ave Seattle, WA 98122
206.323.5770 www.hsdc.org

# Medications List

Name: _____ Date of Birth: _____

Medications current as of: _____ _____ _____

_____ _____ _____

Please list all medications and dosages that you are currently taking. This information is confidential and will be kept in your client file. Should you need to make any changes to the form, you are welcome to do so in-person or over the phone at 206.323.5770.

**This list must be reviewed at each diagnostic hearing test.**

| MEDICATION NAME | DOSAGES |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

## Authorization for Use/Disclosure of Protected Health Information

HSDC
Hearing, Speech & Deaf Center

Artz Communication Center
1625 19th Ave Seattle, WA 98122
206.323.5770 www.hsdc.org

Client Name: _____ Birthdate: _____

## Release of Protected Health Information

My protected health information may be disclosed to the following:

**Name**: _____ **Facility**: _____

Phone: _____ Fax: _____

Address: _____

**Name**: _____ **Facility**: _____

Phone: _____ Fax: _____

Address: _____

**Name**: _____ **Facility**: _____

Phone: _____ Fax: _____

Address: _____

**Name**: _____ **Facility**: _____

Phone: _____ Fax: _____

Address: _____

**Signature** required for release/obtain/exchange for information. **I understand that by signing below:**

- I authorize HSDC to release protected health information to the parties listed above.
- I authorize HSDC to release any information required to insurance companies, medical providers, and other as required by law or court order.
- I understand that in order to revoke these rights, a written notification must be submitted to HSDC.
- Authorizing the disclosure of health information is voluntary. My treatment or eligibility will not be conditioned upon my authorization of this disclosure.

_____ _____

Signed name of patient/personal representative Date

_____

Printed name of patient/personal representative

HSDC
Hearing, Speech & Deaf Center

Artz Communication Center
1625 19th Ave Seattle, WA 98122
206.323.5770 www.hsdc.org

# Financial Agreement and Attendance Policy

## Financial Agreement

I authorize treatment of the person named below and agree to pay all fees for such treatment.

- I authorize my insurance benefits to be paid directly to the provider of service and I am financially responsible for non-covered services, co-pays, deductibles, and exhausted benefits.
- I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges
- I am financially responsible for a billing fee. I understand that balances over 60 days may incur a billing fee of 1% per month (12% APR), (RCW 19.52) with a minimum charge of $1.00 monthly.
- I understand that HSDC charges a $30.00 fee for returned checks (per RCW 62A.2-515 and 520). If the original charge and the resulting NSF fee is not paid within 30 days, the account will be sent to collections.
- In the event it should become necessary to place for collection an unpaid balance due for services rendered to me or my family, I/we agree to interest and collection fees, including attorneys' fees and costs.

## Attendance and Cancellation Policy

All appointments must be cancelled with at least 24 hours' notice.

- A missed appointment/no show fee of $75.00 may be charged for all appointments that are not cancelled with 24 hours' notice. Except in the case of emergency or illness,
- Patients how are more than 15 minutes late to an appointment will be marked as a "no-show" and will need to reschedule.
- If a client misses more than 20% of their appointments, they may be places on "Walk-in" only status, meaning that they will not be given a routine time for scheduled appointments.
- If ongoing attendance is poor or problematic, services may be terminated.

_____ _____

Signed name of patient/personal representative Date

_____

Printed name of patient/personal representative

Revision date: 3/25/16

HSDC
Hearing, Speech & Deaf Center

Artz Communication Center
1625 19th Ave Seattle, WA 98122
206.323.5770 www.hsdc.org

# Privacy Policy Agreement & Acknowledgement of Privacy Practices

Hearing, Speech & Deaf Center ("HSDC") wants you to be aware of the federal government rules and regulations that are in place to protect your health information. HSDC is committed to helping you understand these rules and regulations so that we can most effectively treat you and inform you how information that may identify you and that relates to your health care will be used. Some of these documents must be signed to show you received and understand them.

## NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices is a document that goes into detail to fully inform you about how your health information is used. The Notice of Privacy Practices covers the following topics:

- How HSDC manages and protects your health information
- How you can restrict certain uses and disclosures of your protected health information
- Your rights in requesting information about your protected health information; and
- Contact information if you have any questions or concerns regarding your protected health information.

You are requested to sign this acknowledgment that you received the Notice of Privacy Practices.

### Acknowledgment of receipt of Notice of Privacy Practices

By signing below, I acknowledge that I received a copy of Hearing, Speech & Deaf Center's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be available in the reception area, the website, and that any revised Notice of Privacy Practices will be made available.

_____ _____

Signed name of patient/personal representative Date

_____

Printed name of patient/personal representative

Revision date: 3/25/16