Pathway Audiology

Patient Information

Demographics:

Patient Name _____ Date of Birth _____/_____/_____ Male Female

Address _____ City _____ State _____ Zip _____

Parent/Guardian Name_____ Phone Number (_____) _____-_____

Parent/Guardian Preferred Method of Contact: Call Text Email

Primary Care Physician_____ Phone (if known) (_____) _____-_____

Emergency Contacts: Please include parent/guardian as named above in this section.

Name_____ Phone (_____) _____-_____ Relation to Patient _____

Name_____ Phone (_____) _____-_____ Relation to Patient _____

How did you hear about us? Please circle all that apply and provide names where applicable.

Physician (specify) _____ Friend or Family Member (specify) _____

Mail Newspaper Website Google Facebook KBEST KBYG Other: _____

Patient Portal:

Please provide your email if you would like us to activate your child's secure, online patient portal where you can access reports, invoices, and other documents. You will receive an email with activation instructions.

Email _____

This form was signed by _____ Relation to Patient _____

Parent/Guardian Signature (Required**) _____ Date _____

Pathway Audiology

Patient Authorization

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for use of the information for treatments, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

How may we contact you to confirm appointments? (Please circle all that apply) CALL TEXT EMAIL

May we leave a message or send you a text on your home or cell phone? YES NO

May records be released to or discussed with a member of your family? YES NO

If YES, please name the family members we are allowed to discuss with (please include yourself if filling out for your dependent**):

Name: _____ Relation: _____ Phone Number: (_____) _____-_____

Name: _____ Relation: _____ Phone Number: (_____) _____-_____

Name: _____ Relation: _____ Phone Number: (_____) _____-_____

This form was signed by _____ Relation to Patient _____

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Staff Signature **Date**

210 West 3rd Street
Big Spring, TX 79720
(432) 606-1933

Marisha Beck, Au.D., CCC-A, CH-TM, TX Lic: 80110
Ashley Smith, Privacy Official

Pathway Audiology

Patient Authorization

Clinical

1. I authorize Pathway Audiology, PLLC to perform all recommended/referred diagnostic procedures.
2. ____ I authorize Pathway Audiology, PLLC to complete all measures needed to make a thorough diagnosis and recommendation. I authorize that such diagnostic material may be released to and/or obtained from third-party payors and/or other health professionals. This includes my primary care physician as listed on the Patient Information form and/or other healthcare professionals (listed as follows), as necessary: _____

Financial

3. I authorize Pathway Audiology, PLLC to furnish all information regarding my medical history, diagnosis and treatment of myself to an insurance company regarding my claim for benefits. If, however, said insurer fails to meet this obligation in whole or in part, or if I am non-insured, I agree to be responsible to the fee and cost involved in my treatment. I authorize payment of medical benefits to Pathway Audiology, PLLC and further understand that should my account have to be referred to a collection agency that I am responsible for all fees and costs incurred therein. I hereby authorize Pathway Audiology, PLLC to act on my behalf in accessing medical records when and if needed.

Insurance

4. I authorize Pathway Audiology, PLLC to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records and other diagnostic material about my medical history, services rendered, or recommended treatment. I authorize Pathway Audiology, PLLC to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company on my behalf and in my name listed as "signature on file".
5. I certify that I, and/or my dependents, have insurance coverage with _____ and assign directly to Pathway Audiology, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
6. The above named may use my healthcare information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

This authorization was signed by: _____ (PLEASE PRINT)

_____ _____

Parent/Guardian Signature **Date**

210 West 3rd Street
Big Spring, TX 79720
(432) 606-1933

Marisha Beck, Au.D., CCC-A, CH-TM, TX Lic: 80110

Pathway Audiology

Pediatric Case History

1. What is the primary reason for this appointment? (Circle) Speech Delay Failed Hearing Screening
   Other: _____

2. Do you feel like your child's hearing is stable or fluctuates? (Please Circle) Stable Fluctuates

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, when was their last ear infection? _____
   Has he/she had more than 3 ear infections in a year? ☐ Yes ☐ No

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 age 30? ☐ Yes ☐ No
   If yes, what relation do they have to your child? _____

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. Has your child been evaluated by an Ear, Nose, and Throat (ENT) physician? ☐ Yes ☐ No
   If yes, name of ENT: _____ Where? _____
   Results: _____
   Do you have a copy of the report? ☐ Yes ☐ No

10. Does your child currently wear hearing aids? ☐ Yes ☐ No; If yes, how old are the aids? _____

11. Is your child currently receiving services through Early Childhood Intervention (ECI) or special education in the schools? ☐ Yes ☐ No

12. Do you have concerns with your child's speech? ☐ Yes ☐ No
    If yes, describe: _____

13. Is your child receiving physical therapy, occupational therapy, recreational therapy, and/or speech therapy? ☐ Yes ☐ No
    If yes, which ones(s): _____

Pathway Audiology

Pediatric Case History

14. If your child is school age, do you have concerns about their performance in school? ☐ Yes ☐ No
If yes, describe: _____

15. For testing purposes, please indicate the following (check all that apply):

☐ My child can repeat simple words such as cowboy, baseball, etc.

☐ My child can point to body parts such as ears, nose, eyes, hair, mouth, etc.

☐ My child can follow simple instructions such as "Drop the toy in the bucket."

List interests (e.g., superheroes, Disney princesses, trains, etc.): _____

MEDICAL/BIRTH HISTORY: Please check all that apply.

☐ Measles

☐ Meningitis

☐ Mumps

☐ Allergies

☐ Influenza

☐ Chickenpox

☐ Head Injury

☐ Encephalitis

☐ 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. cytomegalovirus, herpes, rubella, syphilis, toxoplasmosis)

☐ Postnatal infections associated with hearing loss (e.g. herpes, meningitis)

☐ Genetic syndromes/conditions (e.g. neurofibromatosis, Usher syndrome, Waardenburg syndrome, CHARGE syndrome, Down syndrome, Alport syndrome, Treacher Collins syndrome)

☐ Noise Exposure

☐ ADHD or ADD

☐ Social or Emotional Issues

Are there any other concerns that you feel we need to know? _____

_____

_____

_____