Beyond Limits Audiology
6 months - 4 years Case History

Child's Name: ____ Date: ______________________
Birthdate: __________________ Age: ______ ☐Years ____ ☐ Months Gender: ☐Male ☐ Female
Diagnosis: ____
Parents Names: ________________________________ Marital Status: ______________________
☐Birth Parents ☐ Foster Parents ☐ Adoptive Parents ☐ Guardians
Parents Occupation(s): ____
Home Address: ____
Home Phone Number: _________________________ Cell Phone Number: ______________________
Email Address(es): ____
Preferred method of communication: ☐ Home ☐ Cell ☐ Email

Primary Insurance: ____ Phone: _____________________
Insured Name: ____ DOB: ______________________
ID# ______________________________________ Group # ____
Secondary Insurance: ____ Phone: _____________________
Insured Name: ____ DOB: ______________________
ID# ______________________________________ Group # ____

Siblings Names and Ages: ____ ☐Only Child
Who lives in the home with the child? ____
What is the reason for today's visit? ____

Primary Care Physician: _______________________________ Phone Number: _____________________
Referral Source: ____________________________________ Phone Number: _____________________
How did you hear about Beyond Limits Audiology? ____

Birth History

Birth Hospital: _______________________________ Gestational Age at Birth (length of pregnancy): _____ Weeks
Birth Weight: _________☐Grams ☐ Pounds

NICU (Special Care) stay after birth? Yes ☐ No ☐ If yes, how long? ___________________________
Ventilation required? Yes ☐ No ☐ If yes, how long? ___________________________
Any significant infections? Yes ☐ No ☐ If yes, please describe: ______________________
Treatment for Jaundice? Yes ☐ No ☐ If yes, please describe: ______________________
Any other significant birth history? ____
____

Medical History

Has your child had any of the following medical problems? Please check No, Past or Present to the right of the condition:

	No	Past	Present		No	Past	Present
Allergies				Hepatitis			
Asthma				High Fevers			
Cancer				Hospitalization			
Cerebral Palsy				Kidney Problems			
Chicken Pox				Mastoiditis			
Cleft Lip or Palate				Measles			
Concussion				Meningitis			
Cytomegalovirus (CMV)				Mumps			
Developmental Delay				Neurofibromatosis			
Diabetes				Noise Exposure			
Dizziness				Pneumonia			
Ear Infections				RespSyncitial Virus (RSV)			
Ear Surgery				Rubella			
Ear Tubes				Seizures			
Encephalitis				Sinusitis (Chronic)			
Frequent Colds				Tinnitus			
German Measles				Tuberculosis (TB)			
Head Trauma				Vision Problems			
Headaches (Severe)				Other: ________________			

Known Allergies or Dietary Restrictions: ____

Surgical History: ____

Has your child had any scans, x-rays, MRI's or special tests? ☐ Yes ☐ No

If yes, please list and provide results: ____

Current Medications and Dosages (Supplements, OTC and Prescription):

____

Other Medical Concerns or Diagnosis: ____

____

____

Hearing History

Was your child's hearing screened at birth? ☐ Yes ☐ No If yes, what were the results: ___________

Do you have concerns about your child's hearing? ☐ Yes ☐ No If yes, please explain: ___________________

Does your child have a diagnosed hearing loss? ☐ Yes ☐ No If yes:

What type of hearing loss? Which ear(s)? ____

Wears amplification or an implant? ☐ Yes ☐ No If yes, type? ____________________________

Family history of children or young adult with hearing loss (not ear infection): ☐ Yes ☐ No

If yes, who? ____

Developmental History

Do you have any concerns about your child's physical or mental development? ___________________________

Does your child speak another language and/or is another language spoken in the home? ☐ Yes ☐ No

If yes, please list: ____

Communication/Social Skills Difficulties

Communication difficulties (check all that apply): ☐None

☐ Unclear speech ☐A need for messages to be repeated ☐Frustration with communication

☐ Localization difficulties ☐ Attention weaknesses ☐ (Other)____________________________

Is there anything else we need to know about your child? ____

____

____

____

____ ______________________________

Print name of person completing this form Relationship to patient

____ ______________________________

Signature Date

FINANCIAL AND INSURANCE POLICY

Insurance information will be needed before services begin to verify benefits. A copy of your insurance card(s) and driver's license is required. Benefits will be verified upon receipt of your insurance information and you will be made aware of any estimated out-of-pocket expenses. Information gained from insurance companies during verification of benefits is an estimation only and is not guaranteed. Please notify Beyond Limits Audiology of any changes in insurance or Medicaid coverage.

It is imperative that families are aware of their insurance coverage and their potential responsibilities. We will strive to keep open communication in regards to insurance and payment. If you do not have insurance coverage for therapy or assessment services a payment plan may be arranged. Payment for private pay sessions is due at the time of service. Please check with the office to verify the in-network insurance providers at this time. All other insurances will be billed as out-of-network. Unless your child has Medicaid, families are responsible for all co-pays, co-insurances, and any deductible at the time of service. If you utilize out of network benefits payments are due at time of service. As a courtesy will file out of network benefits for private insurance plans by request only and reimbursements will be paid directly to you.

________Parent Initials

For qualified children under the age of three, the Babies Can't Wait program will be billed only when all other sources of payment are exhausted. There may be a family cost participation involved with the BCW program, which will be collected at the time of service or billed to the family. I understand that I am responsible for payment of any services in excess of my Babies Can't Wait IFSP.

________Parent Initials

Katie Beckett Medicaid, SSI Medicaid, Amerigroup, WellCare, and Peachstate are accepted. Primary insurance will always be billed first and Medicaid will be billed secondary unless it is the primary source of payment. Prior approvals are required for therapy services over 8 units per month. Beyond Limits Audiology will submit for prior approvals based on need. Services will be administered after approval has been obtained.

________Parent Initials

If a family does not pay a bill within 30 days of receipt, there will be a 10% late fee added.

________Parent Initial

As in all health-care situations, the client-family is always responsible for payment when all other sources have been exhausted. Therapy services may be put on hold or terminated if there is a problem regarding payment. There is a $39 service fee for all returned checks. Please do not hesitate to contact us regarding questions of billing/payments. We are willing to work with each client to insure a balance between providing therapy services and addressing business issues or concerns.
I have read and understand the above billing policy.

________Parent Initial

CONSENT FOR PAYMENT

I authorize Beyond Limits Audiology to bill my insurance company for direct reimbursement of assessment and therapy services rendered to my child and authorize release of any medical information necessary to process the claim. I assign benefits for filed claims to be paid to Beyond Limits Audiology, LLC and will turn over any payments sent directly to me by my insurance provider that were intended to cover the therapy or assessment services provided by Beyond Limits Audiology. I understand that I am responsible for payment of any services not paid or paid in full by insurance.

________Parent Initials

ATTENDANCE POLICY

Beyond Limits Audiology policy states that we require a 24-hour notice for cancellations. After a one-time occurrence, a $25 fee may be charged for each missed therapy appointment. We know that sickness occurs; therefore, if you think that your child is sick the night before, please call us and give us notice so we can plan accordingly. If your child is fine the next day, we will make every effort to reschedule. In the event of a cancellation, please make an effort on your part to reschedule, as we want your child to benefit from his/her therapy. Additionally, if your child misses 2 consecutive weeks of therapy, we will make every attempt to hold that slot, but cannot guarantee this with an extended absence. Beyond Limits Audiology strives to meet the scheduling needs of every family. If your therapy time does not work for you, please let us know. The Board of Health considers the following signs to indicate communicable disease/illness:

- Vomiting
- Fever over 100 degrees
- Diarrhea
- Sore throat
- Rash /Swelling
- Red, or running eye

Please be sure your child is symptom free for 24 hours before resuming therapy.

Signed: ____ Date: _______________
Parent/ Legal Guardian

CONSENT TO OBTAIN INFORMATION

To help us better serve your child it is very important that we have access to previous evaluations and other relevant information about your child. Please send copies of the reports along with this packet. If you would like us to contact an outside associate and ask them to fax information directly to Beyond Limits Audiology, please provide us with a name, telephone and/or fax number.

Check any of the following professionals your child has been evaluated by:

_____ Dev. Pediatrician _____ Occupational Therapist _____ Neurologist
_____ Speech Therapist _____ Psychologist _____ Orthopedist
_____ Audiologist _____ Physical Therapist _____ Other: ______________________

Detail any of the following agencies who have pertinent information to share:

Agency	Contact Name	Phone	Fax
_________________________	_________________	______________	_____________
_________________________	_________________	______________	_____________
_________________________	_________________	______________	_____________
_________________________	_________________	______________	_____________

I hereby give permission to release my child's health/ medical/ psychological/ educational/ early intervention/ therapeutic records to Beyond Limits Audiology and to discuss my child's care or treatment with appropriate professional staff. I understand that information in my child's records will not be released to any other individual without my specific written consent.

Parent's Name: ____

Parent's Signature: ____ Date: ______________________

HIPAA Consent and Disclosure- Privacy Notice Acknowledgement

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about your child. We understand that his or her medical information is personal to you, and we are committed to protecting that information. As our client, we create medical records about your child's health, our care for him/her, and the services we provide for your child. By law, we are required to make sure that your child's protected health information is kept private.

By signing this form, you consent to our use and disclosure of protected health information about your child for treatment, payment and health care operations. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I acknowledge that the Beyond Limits Audiology (Revision Date, April 1, 2014) has been made available to me. A paper copy of this Notice will be provided any time at my request. This Notice is also displayed in our office and on the Beyond Limits Audiology website www.beyondlimitstherapy.org

Parent Or Guardian's Printed Name:

____

Parent or Guardian's Signature:_________________________________ Date:___________

PERMISSION TO PHOTOGRAPH OR VIDEOTAPE

Beyond Limits Audiology likes to use pictures of students/clients in our website, brochures, invitations, slideshows, etc. This form allows or prohibits Beyond Limits Audiology to use your child's picture or videotape for marketing purposes.

_____ Yes, I give permission for my child to be photographed and/or videotaped for publicity or fund-raising purposes to benefit Beyond Limits Audiology. My child's first name may be used; however, if my child is to be identified by first and last name, I must be notified in advance to give express approval prior to publication.

_____ No, please do not use pictures of my child for anything outside of the center.

Parent's Name: ____

Parent's Signature: ____________________________________ Date: ____________________

CONSENT FOR TREATMENT

I, ______________________ (parent/guardian), knowing that ______________________ (child's name) has a diagnosis requiring audiological testing and/or hearing therapy, voluntarily consent to such care for the aforementioned child by the therapist doing business for Beyond Limits Audiology as may be beneficial in the professional judgment of this child's therapist. I consent to care and treatment that falls within the scope of practice as defined by the State of Georgia for each discipline. I understand that treatment will involve physical participation on the part of the patient, which may involve risks of injury. You are responsible for making your therapist aware of any changes in your child's physical or mental status. I acknowledge that no guarantee has been made to me as the result of evaluation and/or treatment. Beyond Limits Audiology is a teaching facility and supervised students or volunteers may participate in your child's treatment session.

In my absence, I consent that_______________________ (child's name) may receive therapy under the care of: ____.
(List all caregivers, teachers, daycare providers, etc. that may be present during therapy in your absence.)

Signed: ____ Date: _____________________
Parent/Guardian

CONSENT TO EXCHANGE INFORMATION

I authorize Beyond Limits Audiology to release or communicate necessary and pertinent information to physicians, case managers, and insurance companies for my child _____________________. Approved information may be given to, received from, and discussed with the following people directly related to my child's care. Approved information includes written documentation and/or verbal discussion.

_Pediatrician:____

____

____

Parent's Name: ____

Parent's Signature: ____ Date: _____________________

NOTICE OF PRIVACY POLICY
I have read, understand, and agree to the Beyond Limits Audiology Notice of Privacy Policy. I understand I may request a copy of this policy at any time. I consent to receive communication regarding my child's therapy via (circle all that apply) phone messages at home or cell phone, email address.

Parent's Name: ____

Parent's Signature: ____ Date: _____________________

Beyond Limits Audiology

AUTHORIZATION FOR REQUEST OF MEDICAL RECORDS AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THIRD PARTIES

PATIENT NAME: ____________________________ DOB:_____________________________
Address: ____
____

A) I authorize BLPTC to RELEASE my child's medical records to:
Name: ____
Address: ____
State & Zip: ____
Phone: ____________________________ Fax: _______________________________

B) I authorize BLPTC to OBTAIN my child's medical records from:
Name: ____
Address: ____
State & Zip: ____
Phone: ____________________________ Fax: _______________________________

Please check information that may be released. (Please note that only records that have been ordered by our office will be released.)
_____ All records (will include Audio, ST and OT Evaluations, Plans of Care and Office Notes)
_____ Evaluations
_____ Plans of Care
_____ Office Notes

These records are to be:
_____ Picked up – Please sign for receipt of records: ___________________________________
_____ Mailed to: ____
_____ Faxed to: ____
_____ Emailed to: ____
(I acknowledge that I am aware that the email provider is not considered a HIPAA approved secure email provider.)

I hereby authorize this practice to release my medical records, including, but not limited to all of the above. By signing this consent, I completely release the entity, facility, or medical practitioner from any and all liability which may result or could result from the release of such information. I also understand this authorization is only valid for 12 months. However, I reserve the right to revoke this authorization at any time.

SIGNED: ___________________________________ DATE: __________________

___________________________________ ___________________________
Printed Name Street Address

___________________________________ ___________________________
relationship to patient City, State, Zip Code

____
contact number

WITNESS: ___________________________________ DATE: __________________

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