# Beyond Limits Audiology
# School Age Case History

Child's Name: _____ Date: _____
Birthdate: _____ Age: _____ 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: _____

## Reason For Hearing Test

Referred by: School ☐ Pediatrician ☐ Therapist ☐ Parent Concern ☐

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? _____
Treatment for Jaundice? Yes ☐ No ☐ If yes, please describe: _____
Any congenital defects? 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: _____

_____

_____

## 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? _____

Preferential seating in the classroom? ☐ Yes ☐ No

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

If yes, who? _____

## Educational History

Current School: _____ ☐ Home schooled ☐ Private ☐ Public

Current Grade Level: _____ ☐ Pre-school ☐ Day care

Does your child have a current IEP? ☐ Yes ☐ No If yes, please explain: _____

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_____

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: _____

_____