USF
UNIVERSITY OF
SOUTH FLORIDA

Hearing Clinic
Phone: (813) 974-8804
Fax: (813) 905-9819
Email: hearingclinic@usf.edu

Thank you for choosing the USF Hearing Clinic. We would like to provide you with a few items to prepare for your upcoming visit with us.

Before your appointment

- Directions to the clinic are available in your new patient paperwork.
- Please have all new patient paperwork filled out and bring your driver's license, insurance card, and list of medications.
- If you are unable to complete the paperwork before the appointment, please arrive 30 minutes before your appointment.
- The red pass will be for your vehicle. You should park in a green RESERVED PSY/CSD spot and display the red parking pass on your dashboard. If you will be parking in the handicapped spaces, you will still need to display the red pass.

Your appointment is scheduled for:

_____

If you are not able to make your appointment, please call 813-974-8804 to cancel.

We look forward to seeing you soon!

3711 USF Laurel Drive Tampa FL 33620

USF UNIVERSITY OF SOUTH FLORIDA
COLLEGE OF BEHAVIORAL & COMMUNITY SCIENCES

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PEDIATRIC CASE HISTORY FORM FOR AUDIOLOGY

IDENTIFYING AND BACKGROUND INFORMATION

Child's Name: _____ SS#: _____
Last First Middle

Father: _____ DOB: _____

Address: _____ Phone (Home): _____ (Cell) _____

Mother: _____ DOB: _____ Education: _____

Address: _____ Phone (Home): _____ (Cell) _____

E-Mail: _____ Parents' current status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Person completing questionnaire: _____

Reason you are bringing this child for the evaluation: _____

_____

Where did you hear about our services? _____

BIRTH AND PRENATAL HISTORY

Birth weight: _____ Premature? ☐ Yes ☐ No

Were there any complications during pregnancy or at birth? _____

_____

List drugs/medication taken during pregnancy: _____

At birth did the baby have the following: (please check)

Anoxia (blue color) ☐ Yes ☐ No
Jaundice (yellow color) ☐ Yes ☐ No
Swallowing problems ☐ Yes ☐ No
Respiratory distress (breathing problems) ☐Yes ☐No
Remain in the hospital ☐ Yes ☐ No, if "yes", how long? _____
Sucking problems ☐ Yes ☐ No

MEDICAL INFORMATION

Name of child's physician: _____ Date of last visit: _____

Reason for last visit: _____

Please list any medications that the child is currently taking: _____

_____

Check if the child has ever had the following:

☐ Ear infection ☐ Ventilation tubes in the eardrum ☐ Excessive ear wax ☐ Seizures
☐ Ear pain ☐ Ringing in ears ☐ Meningitis ☐ Dizziness
☐ Head injury ☐ Allergies ☐ Migraines ☐ Asthma ☐ High fever
☐ Major medical problems (i.e., heart, lung, physical disabilities) Please explain:_____

_____

Ear surgeries? ☐ Yes ☐ No. If "yes", list date and reason: _____

_____

DEVELOPMENTAL HISTORY

Do you have any concerns with your child's development? ☐ Yes ☐ No. If "yes", explain _____

_____

SPEECH AND LANGUAGE DEVELOPMENT

Which languages are spoken at home? _____

What is the child's primary language? _____

At what age did child do the following?

____ Babble ____ Imitate sounds ____ Say first word ____ Use 2 to 3 word phrases ____ Make complete sentences

About how many words are in your child's vocabulary? ____

Can you understand your child's speech? ☐ Yes ☐ No Can other people understand your child's speech? ☐Yes ☐No

Does your child follow commands and directions? ☐ Yes ☐ No. If "No", explain _____

_____

Are you concerned about your child's speech and language development? ☐ Yes ☐ No. If "yes", explain _____

_____

HEARING HISTORY

Did child pass the newborn hearing screening? ☐ Yes ☐ No. If "no", explain _____

Check all that apply:

☐ The child has trouble hearing ☐ TV/radio is excessively loud
☐ The child needs to hear instructions several times ☐ There are sounds that make child uncomfortable
☐ It helps the child when people speak loudly ☐ The child "tunes in and out" of listening situations
☐ My child's teacher/daycare worker has mentioned my child having trouble hearing in school.

Are you concerned about your child's hearing? ☐ Yes ☐ No. If "yes", explain _____

FAMILY HEARING HISTORY

Do any family members of the child have a hearing loss:

Relationship to child	Age	Age problem began	Severity of hearing loss	Hearing aids (yes or no)

SCHOOL INFORMATION (check all that apply)

What school does your child attend? _____ Grade _____ Teacher _____

Is your child having any academic trouble in school? ☐ Yes ☐ No. If "yes", explain _____

_____

Does your child receive any special services at school/daycare or privately (i.e., speech therapy, physical therapy, occupational therapy, learning disabled class, bilingual services, psychological services, psychiatric services, neurological services, visual therapy, medical intervention, etc.)? ☐ Yes ☐ No. If "yes", please explain

_____

Client/Patient Authorization regarding Research Studies, Mode of Communication and Educational Use of Recorded Sessions

Participation in research projects:
Clients/patients may be asked by researchers in the Department if they would be interested in participating in a research study pertaining to their condition. When contacted, clients will be given an opportunity to review information about the study in order to decide whether or not they wish to participate. **Participation in any research study is always optional and will not affect the clinical care delivered to the client. Clients/patients who do not wish to be contacted regarding opportunities to participate in research may opt out at any time by contacting the clinic or by checking the statement below.** Initials_____

___ Please do NOT contact me with opportunities to participate in research

Electronic communication and transmission of service related information:
Authorization is given to the Speech, Language, Hearing Center of the Department of Communication Sciences and Disorders, University of South Florida, 4202 E. Fowler Ave., Tampa, Florida 33620-8150, to communicate with me via **email, telephone (voice/text) and/or fax,** regarding therapy and/or assessment for the above named client. I acknowledge that the Speech, Language, Hearing Center of the Department of Communication Sciences and Disorders cannot be responsible for non-secured communication. Initials_____

Acknowledgement of the recording of sessions (audio and video):
The University of South Florida Department of Communication Sciences and Disorders operates a clinical facility primarily for the training of future professionals in Speech-Language Pathology, Audiology, and Aural (Re)Habilitation. All clients/patients seen in the clinic for diagnostic and therapeutic services must agree to the recording of sessions. Recordings may be reviewed and used by faculty, staff and students as part of a client/patient's plan of care, as part of a research project and/or to facilitate instructional objectives for students enrolled in the program. Appropriate safeguards related to privacy and confidentiality will be utilized for the use and storage of such recordings and this specific authorization regarding the recordings is attached below and must be signed by each patient.

"I understand the above and hereby release to the University of South Florida Department of Communication Sciences and Disorders, the right to make audio and video recordings or to photograph said person in any and all phases of the educational or remedial process and to put the audio and video recordings or photographs to any legitimate educational or training uses. All recordings, photographs and their reproductions shall remain the property of the Department of Communication Sciences and Disorders of the University of South Florida. It is further agreed that in the event the Department of Communication Sciences and Disorders of the University of South Florida or its assigns shall become a party defendant to litigation by said persons as a result of the legitimate use of said audio and video recordings, photographs, and/or descriptive literature or sound tracks, (I/We) shall hold harmless and indemnify it or its assigns from any judgment which may be entered against it or its assigns."

Signature:_____ Date:_____
Client/Parent/Guardian

USF HEALTH

CONSENT TO TREATMENT AND CARE OF MINORS

In my absence, I, _____ ,hereby
Parent / Legal Guardian

give consent for medically necessary treatment and care, including emergency treatment, to

_____ , by health care providers
Child's Name

affiliated with the University of South Florida/USF Physicians Group.

_____ _____
Signature of Patient/Legal Guardian *Date*

_____ _____
Witness *Date*

Emergency Phone Numbers

Mother: _____ Home: _____
Name Work: _____

Father: _____ Home: _____
Name Work: _____

Legal Guardian: _____ Home: _____
Name Work: _____

Patient's Name: _____

Medical Record #: _____

Form #1107-006 (rev 6/06)

USF HEALTH

CONDITIONS OF TREATMENT BY UNIVERSITY OF SOUTH FLORIDA (USF) COLLEGE OF MEDICINE

Permission for Treatment: Permission is hereby granted for physicians, residents, employees or agents of the USF College of Medicine ("USF Physicians Group") (collectively, the "Provider") to render the patient named below such medical and surgical treatment as is deemed necessary.

Authorization for Release of Information: The Provider (through its employees or contracted copying services) may disclose the patient's medical record and account to:

1. Any person or corporation which is or may be liable for all or any portion of the patient's charges, including but not limited to insurance companies, health care service plans, and worker's compensation carriers to the extent necessary to determine insurance benefits, liability for payment and to obtain reimbursement.
2. Any referring physician to ensure continuity of medical care.
3. Other treatment providers within the USF College of Medicine/USF Physicians Group. (The USF Medical Clinics combine all records pertaining to each individual patient in one file. Therefore, in the event a patient is seeing more than one Provider within the USF College of Medicine/USF Physicians Group, each Provider will have access to the records created by every other Provider for that patient.)

Financial Agreement: (Please initial as applicable)

_____ **Assignment of Insurance Benefits**: I request my insurance carrier to pay to University Medical Service Association, Inc. all benefits due me related to my pending claim for medical and surgical services. I agree to pay all applicable deductible and coinsurance amounts due and other fees for services rendered for which my insurance plan/HMO is not liable for payment to the Provider, and agree to pay the costs of collection including reasonable attorney's fees in the event of legal action to collect such amounts.

_____ **Medicare B Authorization**: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of this physician or supplier, any information needed for this or a related Medical Claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

_____ **Self-Paying Patient.** I have been informed that the USF College of Medicine/USF Physicians Group does not have a contract to participate with my insurance plan or HMO, and the requested services have not been authorized by my insurance plan/HMO, as applicable. I am requesting medical services as a fee-for-service, self-paying patient. I agree that I am responsible for all charges incurred as a result of this visit, including but not limited to all medical/surgical professional services, laboratory, radiological, and any other ancillary services. I agree to pay the costs of collection including reasonable attorney's fees in the event of legal action to collect this account.

_____

Print Patient's Name

_____ _____

Signature (Patient, Patient Representative) Date

_____ _____

Signature (Witness) Date

_____ _____

Signature (Financially Responsible Party) Date

_____ _____

Signature (Witness) Date

USF HIPAA COVERED COMPONENT
ACKNOWLEDGEMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES AND NOTICE OF HEALTH CARE ARRANGEMENT

Effective August 1, 2015

By signing below, I acknowledge that I have been provided a copy of this Joint Notice of Privacy Practices and Notice of Organized Health Care Arrangement and have thereby been advised of how my health information may be used and/or disclosed, and how I may obtain access to and control this information.

_____ _____

Signature of Patient (or Authorized Personal Representative) Date

_____ _____

Print Name of Patient (or Authorized Personal Representative) Authority of Personal Representative
(e.g., parent, legal guardian, health care surrogate)

DOCUMENTATION OF GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES AND NOTICE OF HEALTH CARE ARRANGEMENT

The patient presented for his/her service on this date and was provided a copy of the Joint Notice of Privacy Practices and Notice of Health Care Arrangement. A good faith effort was made to obtain a written acknowledgment of receipt of the Notice. However, an acknowledgment of receipt was not obtained because of the following reason(s):

- ☐ Patient refused to sign the Acknowledgement of Receipt.
- ☐ Patient was unable to sign or initial the Acknowledgement of Receipt.

_____ _____

Signature of employee completing this form Date

_____

Print name of employee

Medical Record Number: _____

Or Affix Patient Label:

Scan/File Original in the Medical Record

USF HEALTH

Patient Name:_____ MRN Number:_____

As a result of the American Recovery and Reinvestment Act, the USF Physicians Group is required to collect patient data regarding race, ethnicity and language as part of information provided to the Centers for Medicare & Medicaid Services (CMS) under the Meaningful Use requirements. This information is required for all patients.

Accordingly, we are required to request that you indicate your racial background, ethnicity and primary language by indicating one of the following:

Race

___ American Indian/Alaska Native
___ Asian
___ Black
___ Native Hawaiian/Other Pacific Islander
___ White
___ Declined
___Unknown

Ethnicity

___ Hispanic or Latino or Spanish Origin
___ Not Hispanic or Latino or Spanish Origin
___ Declined
___ Unknown

Please note that you have the option of indicating "declined" above.

Language_____

Other required data to offer better service to you:

Preferred Method to Notify You of Upcoming Appointment (*if you currently subscribe to the FollowMyHealth patient portal, you will receive appointment reminders through this method*)

_____Cell Phone Number _____

_____Home Phone Number_____

_____E-Mail – E-Mail Address_____

_____Text Message – Phone Number to Text_____

_____Do Not Call Me

_____No Response

*DATE ENTERED:*_____*BY:*_____*(Initials)*

USF HEALTH

PRIOR EXPRESS CONSENT

FOR COMMUNICATIONS FOR DEBT COLLECTION AND PAYMENT PURPOSES

I expressly agree and consent that, in order for University Medical Service Association, Inc. ("UMSA"), and its agents and affiliates, to service my account including debt collection and payment purposes, UMSA, or any of its agents or affiliates, may contact me by telephone at any telephone number associated with my account, including any wireless/cellular telephone numbers, which could result in charges to me. UMSA, or any of its agents or affiliates, may also contact me for debt collection and payment purposes by sending text messages or e-mails, using any e-mail address I provide to UMSA. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device.

I have read this Consent and agree that UMSA may contact me as described above. I hereby affirm that either (i) I am the patient and sign this Consent of my own behalf, or (ii) if I am signing this Consent on behalf of the patient, I have reviewed this Consent with the patient and he/she has expressly authorized me to sign this Consent on his/her behalf.

_____ _____

Patient or Patient's Authorized Representative Date

_____

(Relationship to Patient)

Patient Refused to Sign

_____ _____

(Signature of USF Health Rep) Date

USF Health
Release of Information

13330 USF Laurel Drive, MDC 33, Tampa, FL 33612
Phone (813) 974-9818 Fax (813) 974-4280

Authorization to Release written and verbal communication of Medical Records, PHI, to Additional providers, family member, Friend and/or Organizations.

Patient Name: _____

DOB: _____ Medical Record Number _____

Password for verbal communication _____ (choose a password that you will share with the individuals you want us to verbally communicate with. We will request this password before releasing any information.)

I authorize release of PHI as defined under "HIPAA" as described on the below authorization form to the following person(s), family member, physician(s) and or organization(s):

By signing this form I understand that I am authorizing the designated medical records custodians or database custodian to use and/or disclose my protected health information (PHI) as defined under 45 CFR 164.501, the federal regulations implementing the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as described below to the following person(s) or organization(s)

Name of authorized person(s) or Physician(s: _____

Relationship to Patient: _____

Street Address: _____

City, State and zip code: _____

Telephone number: _____

Fax number: _____

Purpose: _____

Date: _____

Signature of patient or personal representative _____

Printed name of patient or personal representative (circle one) _____

Relationship to patient giving representative authority to act for patient _____

Patient or personal representative was given a copy of this form ☐ Yes ☐ No

USFPG Staff member completing this process _____

Date _____

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USF HEARING CLINIC POLICIES

All services are provided under the supervision of licensed and certified audiologists.
Policies relating to patient responsibilities are outlined below:

Attendance: Regular attendance is a critical component in assuring effective treatment. There are many more individuals needing services than our Clinic can accommodate. We ask that you inform the Clinic as soon as possible if you are unable to make your appointment as it may be possible to make-up or reschedule. Cancellations will require at least two hours prior notification. If an appointment is not canceled at least two hours prior to the scheduled time, it will be considered a no-show. If excessive cancellations occur, they will be dealt with on an individual basis and may result in termination of Hearing Clinic services.

Promptness: We try very hard to accommodate all patients and make every effort to be punctual for your appointment. Therefore, appointments cannot be extended in cases of late arrival. If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule. We ask that everyone try to arrive 10 minutes before their scheduled appointment to allow time to obtain parking permits and fill out any necessary paperwork.

Family Involvement: We welcome and encourage family members to attend appointments. We do ask that small children be supervised at all times. We are not able to provide childcare during patient appointments. In accordance with USF polices parents/guardians of minors and caregivers must be on-site while the patient is in our facilities.

Student Observation: The Clinic is part of the clinical education program for students in the Department of Communication Sciences and Disorders at the University of South Florida. Graduate students work directly with patients under the supervision of Clinical Instructors at all times. Students are also required to periodically observe a variety of appointments as part of their learning experience. Students are aware of their ethical responsibilities regarding confidentiality of information.

Video Recording: Sessions are sometimes recorded as a means of assessing progress, evaluating the effectiveness of therapeutic approaches, or as a tool in therapy or teaching. Students periodically review and discuss recordings with their Clinical Instructor. Patient's consent to being recorded and confidentiality is assured. Recordings or other information NEVER leave the facility without your written consent.

Release of Information: A file is established for each patient containing reports and information regarding services. We often work cooperatively with other community professionals in coordinating services. To protect the confidentiality of patient records, we require your written permission before we communicate in any form with others about aspects of your care. Authorization to Send/Receive Information forms are available through the Clinic office and remain valid for one calendar year from date of signature.

The University Clinic Setting: The Clinic calendar coincides with that of the University. You will be notified well in advance of Clinic closures during University breaks and holidays. Also, student clinicians usually alternate from one semester to the next.

Fees for Services: Fees are charged for Clinic services. Our fees are competitive with those charged at other agencies in the community. A fee schedule is available in the Clinic Office. The hearing clinic also reserves the right to charge a nominal fee for patients that fail to cancel their appointments in a timely manner.

Insurance: The Clinic can often bill your insurance company when services provided by the Clinic are included in your health care policy. Please note that not all hearing services are covered by insurance. The Clinic can help determine if your policy provides these benefits.

Payments: Payment must be made at the time of service. Check with the Clinic Services Representative should you have questions. The Clinic accepts cash, checks, and credit cards.

I have read and understand the above information. _____ _____

Patient/Parent/Guardian Signature Date

USF UNIVERSITY OF SOUTH FLORIDA
COLLEGE OF BEHAVIORAL & COMMUNITY SCIENCES

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Phone: (813) 974-8804
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Email: hearingclinic@usf.edu

Directions to the USF CSD Hearing and Speech-Language Clinics

**Please do not use the mailing address: ~~4202 Fowler Ave.~~

Building Address: 3711 USF Laurel Dr, Tampa, FL 33612

From I-275 (Downtown Tampa or Airport Area)

- Exit I-275 to Fletcher Avenue (exit 52)
- Drive east on Fletcher Avenue, past Bruce B. Downs Blvd. to Magnolia Drive
- Turn right on Magnolia Drive and drive south
- Turn left at 2nd traffic light onto Citrus Drive - opposite Moffitt Cancer Center
- Turn right at the traffic circle onto Laurel Drive-building is on the right side look for the sign for 3711 CSD. Parking Directions are on next page.

From I-75 (from Areas North, South, or East of Tampa)

- Take Fletcher Avenue (exit 266) and drive west to Magnolia Drive
- Turn left on Magnolia Drive (at light) and drive south
- Turn left at 2nd traffic light, Citrus Drive - opposite Moffitt Cancer Center
- Turn right at the traffic circle onto Laurel Drive-building is on the right side look for the sign for 3711 CSD. Parking Directions are on next page.

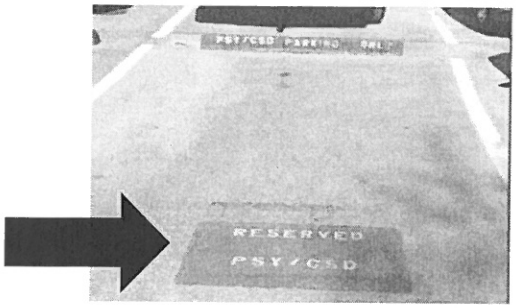
Fowler Avenue Entrance

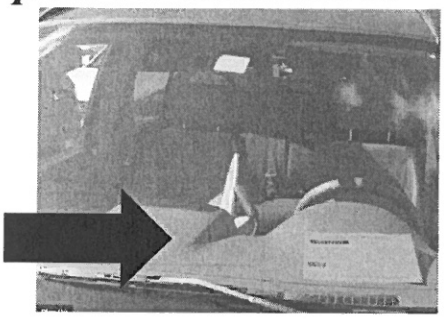
- Turn onto Leroy Collins Blvd. into USF campus main entrance
- Turn left at 1st stop light onto Alumni Drive
- Turn right onto Magnolia Drive
- Turn right onto Citrus Drive - opposite Moffitt Cancer Center
- Turn right at the traffic circle onto Laurel Drive-building is on the right side look for the sign for 3711 CSD. Parking Directions are on next page.

Parking at USF CSD Hearing and Speech-Language Clinics

Please park in the reserved spots marked PSY/CSD in Lots 9A or 46.

Please display <u>RED</u> clinic parking pass on dashboard.





Lot 9A

- Lot 9A is located past the building on the Left (assigned reserved parking spaces are closest to the Psychology Building). When you exit your car, you will want to head back to the CSD Building which will be on your left.

Lot 46

- Additional parking is available in lot 46, which is located past the building and playground on the Right. Once you enter the parking lot stay to the right, closest to the playground and continue to keep right. This parking lot has several sections (assigned reserved parking spaces are located at the farthest end from where you entered, back towards Citrus Drive.) When you exit your car, please enter the CSD building from the closest doors and walk down the hallway past the bathrooms and towards the sliding doors.

<u>The Hearing Clinic</u> is located on the first floor of the Communication Sciences & Disorders Building and <u>The Speech Clinic</u> is located on the second floor.

<u>Red</u> arrows indicate where reserved spots are located in each parking lot

FIND YOURSELF LOST ON CAMPUS?
Call USF Visitor Services! 813-974-4607