The UTHSC Audiology and Speech Clinics at UT Conference Center are an educational and research facility in the Department of Audiology and Speech Pathology. The services we provide include evaluations and treatment for children and adults with hearing loss. Graduate students in audiology or speech in the department provide the services under the supervision of the department’s licensed audiologists and speech-language pathologists. Evaluations normally are 1 to 1 ½ hours in length.

INSURANCE
We will file a claim with all insurance providers (primary and secondary) for all patients. Please be aware that some insurance providers do require the patient to get an Out-of-Network authorization from the primary care doctor before being seen at our facility. Medicare and most health insurance companies will pay for the diagnostic procedures in our clinics, but will not cover the cost of hearing aids or fitting fees. Medicare requires that we collect 20% of testing charges due on date of service. Payment is expected at the time of service (including co-pays) by visa, master card, discover, check or cash.

FEES
The clinic charges for each procedure that is performed. If you were referred by the VA, they will pay for all visits.

REDUCED RATES
For speech patients, we offer reduced rates to those who qualify based on a sliding fee scale. It depends on the number of people in the home and the gross household income. If you feel that you may qualify for a reduced rate, please bring either a complete copy of your last year’s tax return or, if you do not file a tax return, the last 3 months of your bank statements. You may also call us at (865) 974-5453 with questions.

CANCEL/RESCHEDULE POLICY
If you are unable to keep your scheduled appointment, you are expected to call the clinic and cancel at least 24 hours prior to your appointment. If you do not call to cancel or to reschedule, the missed appointment will be counted as a “No-Show Appointment.” After two “No-Shows,” we may be unable to reschedule an appointment for you. In this packet, we have included a more detailed description of our policy.
### UTHSC Audiology Clinic
#### Patient Registration

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
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<tbody>
<tr>
<td><strong>Patient Name</strong></td>
<td>(Last)</td>
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<tr>
<td><strong>Address</strong></td>
<td>____________</td>
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<td><strong>City</strong></td>
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<td><strong>State</strong></td>
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<td><strong>Zip</strong></td>
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<tr>
<td><strong>Patient Age</strong></td>
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<td><strong>Home Phone</strong></td>
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<tr>
<td><strong>Cell Phone</strong></td>
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<tr>
<td><strong>Patient Sex</strong></td>
<td>M</td>
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<tr>
<td><strong>Patient DOB</strong></td>
<td>____________</td>
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<tr>
<td><strong>Social Security #</strong></td>
<td>____________</td>
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<tr>
<td><strong>Emergency Contact</strong></td>
<td>(Name)</td>
</tr>
<tr>
<td><strong>Relationship</strong></td>
<td>____________</td>
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<td><strong>Address</strong></td>
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<td><strong>City</strong></td>
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<td><strong>Zip</strong></td>
<td>____________</td>
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<tr>
<td><strong>Birth Date</strong></td>
<td>____________</td>
</tr>
<tr>
<td><strong>Home Phone</strong></td>
<td>____________</td>
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<tr>
<td><strong>Employer</strong></td>
<td>____________</td>
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<tr>
<td><strong>Work/Cell Phone</strong></td>
<td>____________</td>
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<tr>
<td><strong>Name</strong></td>
<td>____________</td>
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<tr>
<td><strong>Relationship</strong></td>
<td>____________</td>
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<tr>
<td><strong>SS#</strong></td>
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<td><strong>Address</strong></td>
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<td><strong>City</strong></td>
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#### Insurance Information

<table>
<thead>
<tr>
<th>Primary Insurance</th>
<th>Secondary Insurance</th>
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<tr>
<td><strong>Subscriber Name:</strong></td>
<td><strong>Subscriber Name:</strong></td>
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<tr>
<td><strong>Policy/ID #</strong></td>
<td><strong>Group #</strong></td>
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<tr>
<td><strong>Insured's DOB</strong></td>
<td><strong>Insured's DOB</strong></td>
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<tr>
<td><strong>Insured SS #</strong></td>
<td><strong>Insured SS #</strong></td>
</tr>
<tr>
<td><strong>Pt.’s Relation to Insured</strong></td>
<td><strong>Pt.’s Relation to Insured</strong></td>
</tr>
</tbody>
</table>

The above information is true to the best of my knowledge. I authorize this medical treatment facility to furnish information to my insurance carriers concerning my illness and treatments to process my claim and I authorize my insurance benefits to be paid directly to **UT Audiology Clinic**. I understand that I am financially responsible for any balance.

**Signature** ____________  **Date** ____________
**Medication List**

Please list below all **medications, supplements, vitamins, etc.** that you are currently using. Be sure to include the dosage and method. You may also attach a list for your convenience.

<table>
<thead>
<tr>
<th>Name of medication</th>
<th>Dosage (amount &amp; how often)</th>
<th>Method (oral, injection, patch)</th>
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**Do you currently use tobacco products (within the past 24 months)? Circle one - Yes or No**

If Yes, what type and how often? ________________________________________________________________

**Printed Name: __________________________ Signature: ________________________________________**

**Date Completed: ______________**

**Date Updated: ______________ Initials: __________**

**Date Updated: ______________ Initials: __________**

*****THE SECTION BELOW TO BE FILLED OUT BY PROVIDER*****

_____ (1036F) – No

_____ (4004F) – Yes, and patient received tobacco cessation intervention (counseling, pharmacotherapy, or both)

_____ (4004F-8P) – Yes, but did not receive tobacco cessation intervention (counseling, pharmacotherapy, or both) or screening not performed (reason not specified)
A copy of your results will be sent to the referring physician. I hereby authorize the University of Tennessee Hearing and Speech Center to receive and/or release information to the additional names listed below. You will need to provide both name and address. Everyone listed will also receive a copy of your medical report.

**Primary Care Doctor * required**

<table>
<thead>
<tr>
<th>Name</th>
<th>Name</th>
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<tbody>
<tr>
<td>Address</td>
<td>Address</td>
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<td>City</td>
<td>State</td>
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<tr>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

Signature of patient, parent or guardian

Date

Signature of staff

Date

Date Updated: _______  Initials: _______

Date Updated: _______  Initials: _______

Date Updated: _______  Initials: _______

Date Updated: _______  Initials: _______
TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you indicate that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your audiologist and/or speech-language pathologist about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your provider, we encourage you to ask questions.

I voluntarily request an audiologist and/or speech-language pathologist, as deemed necessary, to perform reasonable and necessary examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I have been given a copy of the University of Tennessee Health Science Center Department of Audiology and Speech Pathology’s (UTHSC ASP) Notice of Privacy Practices that provides a description of health information uses and disclosures. I understand that I have a right to review the notices prior to signing this form. I understand that UTHSC ASP reserves the right to change their notice and practices and that changes will be posted in the office area. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and UTHSC ASP is not required to agree to the restrictions requested. I may revoke this acknowledgement in writing, except to the extent that UTHSC ASP has already taken action.

TO THE PARENT/GUARDIAN OF PATIENT: I give consent for the following adult individuals to bring the patient to UTHSC ASP for any appointment following the initial evaluation and hereby give permission to UTHSC ASP to exchange information with the following individuals. This request will remain in effect until revoked by me in writing.

(Please print)

a) Name: _____________________________________________ relationship: ________________ __ phone:_________________

b) Name: _____________________________________________ relationship: ________________ __ phone:_________________

c) Name: _____________________________________________ relationship: ________________ __ phone:_________________

d) Name: _____________________________________________ relationship: ________________ __ phone:_________________

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

______________________________________________  _________________________
Signature of Patient or Personal Representative   Date

______________________________________________  _________________________
Printed Name of Patient or Personal Representative    Date

______________________________________________  _________________________
Signature of Witness        Date

______________________________________________  _________________________
Printed Name of Witness        Employee Job Title

rev. 12/2017
Financial Agreement

Name: ___________________________________ Chart #: ______________________

Date of Birth: _____________________________

I understand that I will be charged on a fee-for-service basis, and I agree to pay this amount. I agree I am responsible for any charges not covered by my insurance or other third party guarantor (i.e., VA, CSS, TEIS). I understand that payment will be made at the time services are rendered unless the Center staff has documented payment arrangements as follows:

Please initial only the categories that apply to you.

______ MEDICARE  I understand that Medicare does not cover hearing aid evaluations, hearing aid fittings, earmolds, and hearing aid supplies and accessories. The Center will file a claim for services provided with Medicare and any Medicare supplemental insurance of which we are informed. I understand that I am responsible for any copays and deductibles not paid by Medicare or Medicare supplemental insurance.

______ VETERANS ADMINISTRATION (VA)  I have been referred by the VA. The VA will be billed for all services provided not covered by insurance.

______ TENNCARE  The Center will file claims with my TennCare insurance carrier. I am responsible for any deductible and co-payment required by TennCare.

______ OTHER INSURANCE  The Center will file claims for services and other charges with my insurance carrier. I am responsible for payment of any deductible and co-payments required by my insurance plan. I understand that payment of deductible and co-payments are due at time of service. I am also responsible for paying any non-covered charges as determined by the insurance company per the EOB. I understand that my insurance policy may not cover hearing aids, ear molds, ear impressions, and hearing aid supplies.

______ SCHOOL SYSTEMS  The Center has contracted with ____________ School System for the services. I am responsible for any services not covered by the school system contract.

______ TEIS/CSS/PCSG  I was referred by Tennessee Early Intervention System (TEIS), Children’s Special Services (CSS), or Parent Child Services Group (PCSG). For TEIS and CSS patients, the Center will file claims for the services with my insurance company and will bill any remaining balance to TEIS or CSS. For PCSG patients, services will be billed to PCSG.

______ AETNA / UHC  I am aware that the center is out of network with my insurance and that I will have to pay for services on day of appointment. I will be reimbursed should my insurance cover any portion of my visit.

______ NO INSURANCE/ SELF PAY  I am aware that I will be responsible for paying all charges on the day of my appointment.

It is my responsibility to inform the Hearing and Speech Center of any changes in my insurance carrier and/or my current address. I understand that any changes to this financial agreement affect only subsequent charges, and that I am responsible for all charges to my account. I authorize the UT Audiology Clinic to release any medical or other information necessary to process medical claims with third-party guarantors. I authorize payment of any insurance benefits related to these filed claims to be made directly to the UT Audiology Clinic.

__________________________________  _______________________________
Signature of Client      Date

__________________________________  _______________________________
Clinic Staff      Date
Cancellation Policy

Your appointment is a contract with our Clinic. Your advance notice of a cancellation enables us to offer the appointment time to another patient. Please review our cancellation/late policy.

1. If you do not show for 2 appointments in one semester or 3 appointments in one year (without a phone call to cancel the appointment 24 hours in advance of the appointment time), we may not be able to reschedule your appointment.

2. If you are more than 20 minutes late to your scheduled appointment, it will be necessary to re-schedule your appointment and this will count as 1 No-Show appointment.

3. We follow the Knox County Schools inclement weather policy. If Knox County Schools are closed, our clinics will also be closed.

4. If you or your child wakes up sick on the day of your appointment, please call to reschedule no later than 8:00 am.

It is our desire to work with you and/or your child. If you are unable to follow these guidelines, we will be happy to assist you in finding an alternative clinic. If you have any questions, please feel free to ask the clinic reception staff or contact our program liaison at 865-974-1592.

Thank you.

I, _____________________________, have been informed and understand the above UTHSC Audiology and Speech Clinic attendance policy.

___________________________________________       _______________________
Patient/Guardian Signature                         Date

______________________________________________
Witness
Adult Case History

Please complete the front and back of this form, and bring it with you to your scheduled appointment.

Name: ________________________________ Date of Birth: ___________________ Date: ______________
Occupation: __________________________ Phone: _____________________ Email: __________________

What is the primary reason for scheduling this appointment? _____________________________________________

Have you noticed that you have difficulty hearing? NO YES

The onset of your hearing loss was: Sudden or Gradual

How long have you noticed difficulty hearing? _____________________________________________________

Have you ever had your hearing tested? NO YES

If yes, when and where were you tested? __________________________________________________________

What were the findings? _______________________________________________________________________

Is one ear worse than the other? NO YES Left Right

Do you know what caused the difference? _________________________________________________________

Is there a family history of hearing loss? NO YES Describe: ________________________________

Do you have a history of ear infections? NO YES Left Right Both

If yes, when was your last infection? ______________________________________________________________

Have you ever had ear surgery? NO YES Left Right Both

If yes, what type of surgery, when and by whom? ___________________________________________________

Do you have any other ear problems (pain, fullness, drainage)? NO YES Describe: ______________________

Do you ever have ringing, buzzing, or other noises in your ears? NO YES Left Right Both

If yes, is the noise constant? NO YES

How long have you had noise in your ears? _________________________________________________________

Describe the noise? ___________________________________________________________________________

Do you ever feel dizzy? NO YES

If yes, please describe your dizziness and when it began. ____________________________________________

Do you know the cause of the dizziness? __________________________________________________________

Have you ever worked in loud noise? NO YES Describe: ________________________________

Have you ever served in the Military? NO YES Describe: ________________________________

Do you have any noisy hobbies, (woodworking, shooting, etc.)? NO YES Describe: __________________

Did/Do you wear hearing protection? NO YES Describe: ________________________________
Please circle one and indicate age, if applicable.

<table>
<thead>
<tr>
<th>Condition</th>
<th>NO</th>
<th>YES</th>
<th>Age</th>
<th>Chemo/Radiation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sinus/Allergy Problems</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Cancer</td>
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<td>Kidney Disease</td>
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<td>Stroke</td>
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<tr>
<td>High Blood Pressure</td>
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<tr>
<td>Take Blood Thinner</td>
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<tr>
<td>Pacemaker</td>
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<td>Concussion/Head Injury</td>
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<tr>
<td>Memory Loss/Dementia</td>
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<tr>
<td>Additional serious illness or injury in the last 2 years</td>
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</table>

Have you ever worn hearing aids? NO YES

How long have you worn hearing aids? 

In which ear(s) have you worn hearing aids? Left Right Both

Do you wear hearing aids now? NO YES Left Right Both

What is the make and model of your current hearing aids? 

When did you purchase your current hearing aids? 

The hearing aids have been Satisfactory Unsatisfactory

Describe 

Do you have a cochlear implant? NO YES Left Right Both

Who is your surgeon? 

Which manufacturer? 

When were you implanted? Left Right

Medications (see additional form for full medications list)
I have been given a copy of the Notice of Privacy Practices that provides a description of health information uses and disclosures. I understand that I have the right to review the notices prior to signing this acknowledgment form. I understand that the organization reserves the right to change their notice and practices and that changes will be posted in the office area. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and the University of Tennessee Hearing and Speech Clinics are not required to agree to the restrictions requested. I understand that I may revoke this acknowledgement in writing, except to the extent that the organization has already taken action in the reliance thereon.

Signature of Client or Legal Representative

__________________________________________________________________________

Date

__________________________________________________________________________
Your rights:
You have the right to:

• Inspect and obtain a copy of your health record within 60 days if request is in writing within sixty days of request. There may be a charge to cover the cost of producing your record in hard copy or electronic form.
• Request an amendment of your health record.
• Obtain an accounting of disclosures of your protected health information made, after April 14, 2003 for purposes other than treatment, payment, and healthcare operations.
• Request communication of your health information in a certain way or at a certain location. For example, you can ask that we contact you by mail and not by telephone, or that we contact you at a specific telephone number, or that we use an alternative address for billing purposes, or that we not leave messages on common answering machines. General communication will be provided only at your written request indicating that you understand that contact can be by any reasonable communication method.
• Revise your authorization to list or disclose your protected health information except in the event that action had been taken and the action already has been taken to the extent those services have not been paid out of pocket cash by the patient, family member, or an individual.

Our duties:
We are required to:

• Maintain the privacy of your health information;
• Obtain authorization for the use and disclosure of your protected health information;
• Protect the confidentiality of your protected health information;
• Notify you if there has been a breach of your protected health information;
• Notify you in writing if we are unable to agree to a requested restriction;
• Follow reasonable requests you make to communicate with you as you instruct, for example, to contact you at a certain telephone number or address;
• Provide you a paper copy of this notice of privacy practices upon request, and;
• With written request, provide you with a copy of your electronic health record in electronic form and to transmit the copy directly to another person designated by you. An electronic copy may be attached to an email that does not require encryption; and,

To exercise any of the above rights or to make any of the above requests, your request must be in writing.

The University of Tennessee Health Science Center is not required to treat immediately except for a request for a copy of your health record and will investigate your abilities to comply with all requests prior to granting the request.

The University of Tennessee Health Science Center reserves the right to change this Notice of Privacy Practices and its policies and procedures for privacy practices at any time and to make the changes effective for all protected health information created or received prior to the new effective date and then currently maintained by the UTHSC. Any revised Notice will be posted in the waiting rooms or patient lobbies of our clinical areas and reasonable efforts will be made to advise you of the changes in the Notice, policies and procedures that your next service visit. You may also obtain a copy of the revised Notice upon request.

For More Information or to Report a Problem:
If you have any questions about your rights or duties of the UTHSC practices and procedures regarding protected health information, please contact the appropriate office of the facility where you received services.

If you believe your privacy rights have been or are being violated, you may file a complaint by calling the UTHSC...
This questionnaire is designed to assess your everyday experience with conversation and the sounds around you. Your answers will help the audiologists and staff at UT Audiology Clinic to better understand your individual and unique needs as they work with you to improve your ability to hear.

Please place an “X” in the box that comes closest to your everyday experience. Notice that each choice corresponds to a percentage. You can use this to help you decide on your answer. For example, if the statement is true about 75% of the time, place a mark in the box marked “Generally”.

If you have not experienced the situation we described, try to think of a similar situation that you have been in and respond for that situation. If you have no idea, leave that item blank.

Thank you for your participation.

*Modified with permission.
1. When I am in a crowded grocery store, talking with the cashier, I can follow the conversation.

2. I miss a lot of information when I'm listening to a lecture.

3. Unexpected sounds, like a smoke detector or alarm bell are uncomfortable.

4. I have difficulty hearing a conversation when I’m with one of my family at home.

5. I have trouble understanding the dialogue in a movie or at the theater.

6. When I am listening to the news on the car radio, and family members are talking, I have trouble hearing the news.

7. When I'm at the dinner table with several people, and am trying to have a conversation with one person, understanding speech is difficult.

8. Traffic noises are too loud.

9. When I am talking with someone across a large empty room, I understand the words.

10. When I am in a small office, interviewing or answering questions, I have difficulty following the conversation.

11. When I am in a theater watching a movie or play, and the people around me are whispering and rustling paper wrappers, I can still make out the dialogue.

12. When I am having a quiet conversation with a friend, I have difficulty understanding.

13. The sounds of running water, such as a toilet or shower, are uncomfortably loud.

14. When a speaker is addressing a small group, and everyone is listening quietly, I have to strain to understand.

15. When I’m in a quiet conversation with my doctor in an examination room, it is hard to follow the conversation.

16. I can understand conversations even when several people are talking.

17. The sounds of construction work are uncomfortably loud.

18. It's hard for me to understand what is being said at lectures or church services.

19. I can communicate with others when we are in a crowd.

20. The sound of a fire engine siren close by is so loud that I need to cover my ears.

21. I can follow the words of a sermon when listening to a religious service.

22. The sound of screeching tires is uncomfortably loud.

23. I have to ask people to repeat themselves in one-on-one conversation in a quiet room.

24. I have trouble understanding others when an air conditioner or fan is on.

Comments: