THE UNIVERSITY of TENNESSEE HEALTH SCIENCE CENTER

Department of Audiology and Speech Pathology

Hearing & Speech Center
Patient Registration

For Office Use Only

Referring Provider Name _____ **UT Provider Name** _____ **Pt. ID #**_____

PATIENT INFORMATION

Patient Last Name _____ **First Name** _____ **Middle Initial** _____

Address _____ **City**_____ **State** _____ **Zip**_____

Date of Birth _____ **Sex** __**M** __**F**

Home Phone_____ **Cell Phone** _____ **Emergency Phone** _____

Email Address_____ **SSN**_____

Marital Status __ Single __ Married __ Other

Race __ White __ Black __ Hispanic __ Asian __ Other

Patient Employed __ Yes __ No **Employer** _____

Student Status __ Not a student __ Full-time __ Part-time **School** _____

PARENT/GUARDIAN/SPOUSE INFORMATION

Last Name _____ **First Name** _____ **Date of Birth**_____

Relationship to Patient _____ **SSN**_____ **Employer**_____

INSURANCE INFORMATION

Primary Insurance _____

Subscriber's Name _____

Policy/ID # _____ **Group #**_____

Subscriber's DOB _____

Subscriber's SSN#_____

Patient Relation to Subscriber _____

Secondary Insurance _____

Subscriber's Name: _____

Policy/ID #_____ **Group #**_____

Subscriber's DOB _____

Subscriber SSN #_____

Patient Relation to Subscriber _____

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

Signature _____ **Date** _____

THE UNIVERSITY of TENNESSEE HEALTH SCIENCE CENTER
Department of Audiology and Speech Pathology

Hearing and Speech Center
1600 Peyton Manning Pass
Knoxville, Tennessee 37996-2500
Phone: (865) 974-5451 Fax: (865) 974-4639

PEDIATRIC CASE HISTORY

Child's Name: _____ **Birthdate:** _____**Gender:**_____

FAMILY INFORMATION	
Parent/Guardian: _____ Relationship to child: _____ Date of Birth: _____ Address: (if different from child's address) _____ _____ _____ Home phone: Cell phone: Employer: Occupation:	Parent/Guardian: _____ Relationship to child: _____ Date of Birth: _____ Address: (if different from child's address) _____ _____ _____ Home phone: Cell phone: Employer: Occupation:
Parents' marital status: [ ] married [ ] separated [ ] divorced [ ]single [ ] widowed [ ] other	
Language(s) spoken in the home:	
List all children and adults (other than parents) living in the home:	
Is this child currently in foster care? [ ] Yes or [ ] No If YES, please describe the circumstances:	
Is there a family history of speech difficulties? [ ] Yes or [ ] No If YES, please describe:	

COMMUNICATION CONCERNS		
Please check all that apply:		
[ ] Nonverbal	[ ] Autism	[ ] Spelling/writing
[ ] Unintelligible speech	[ ] Following directions	[ ] Voice quality
[ ] Mispronounces sounds	[ ] Vocabulary	[ ] Reading
[ ] Stuttering	[ ] Grammar	[ ] Hearing
[ ] Auditory processing	[ ] Expressive language	[ ] Other:

When did your child:

Babble?	[ ] 3-6 months	[ ] later	[ ] not yet	[ ] unknown
Say single words?	[ ] 10-12 months	[ ] later	[ ] not yet	[ ] unknown
Say 2 - 3 word sentences?	[ ] 18-24 months	[ ] later	[ ] not yet	[ ] unknown

Describe your child's communication difficulties as completely as possible.

_____

_____

_____

When does your child communicate best?_____

_____

How does your child communicate with other children?_____

_____

MEDICAL INFORMATION:

Were there any problems during pregnancy, labor or delivery? [ ] Yes or [ ] No
If YES, please describe:

Has your child ever had difficulty with any of the following: (check all that apply)

	Check if "yes"	Describe the occurrence(s):
Low birth weight		
Jaundice		
Breathing		
Sucking		
Chewing		
Swallowing		
Choking		
Food preferences		
High fevers		
Ear infections		
Allergies		
Hearing loss		
PE tubes		

MEDICAL INFO (cont.)	Check if "yes"	Describe the occurrence(s):
Upper respiratory infections		
Fine motor skills (e.g., using hands, holding a pencil)		
Gross motor skills (e.g., standing, walking)		
Vision		
Sensory processing (e.g., unusual response to sound, touch, food)		
Other:		

Has your child had any medical diagnoses (e.g., Cerebral Palsy, Down Syndrome), major illnesses, surgeries or injuries? [ ] Yes or [ ] No

If YES, please describe._____

_____

DEVELOPMENTAL & SOCIAL INFORMATION				
When did your child:				
roll over?	[ ] at 3-5 months	[ ] later	[ ] not yet	[ ] unknown
crawl?	[ ] at 6-9 months	[ ] later	[ ] not yet	[ ] unknown
pull up?	[ ] at 6-9 months	[ ] later	[ ] not yet	[ ] unknown
sit alone?	[ ] at 4-6 months	[ ] later	[ ] not yet	[ ] unknown
walk?	[ ] at 10-14 months	[ ] later	[ ] not yet	[ ] unknown
Describe how your child plays with other children.				
Describe how your child interacts with adults.				
What activities does your child like? Dislike?				
Do you or anyone else have any concerns about your child's behavior?				
Compared to other children your child's age, describe how your child is able to sit, stand, run, use his/her hands. Indicate if you have concerns regarding clumsiness or other physical abilities.				

Please outline a schedule of activities that your child carries out on a typical day.

_____

_____

_____

_____

PRESCHOOL/SCHOOL INFORMATION
Does your child currently attend a: [ ] Day Care [ ] Pre-School [ ] K-12 [ ] Home School If so, please complete the following:
Name of School:
City: County:
Current Teacher's Name:
Grade Level:_____
Has the school staff made any comments about your child's speech? [ ] Yes or [ ] No If YES, please explain.
Do you have any concerns about your child's performance in school? [ ] Yes or [ ] No If YES, please explain.
Has your child received any special services (speech therapy, physical therapy, learning resources, special school class, etc.)? [ ] Yes or [ ] No If YES, please explain. Does your child have an IFSP, IEP or 504 plan? [ ] Yes or [ ] No If YES, please explain.

Person completing this form: _____

Relationship to child: _____

Date: _____

Attendance Policy

Welcome to the University of Tennessee Hearing and Speech Center. Our goal is to provide state of the art assessment and treatment services to you and/or your family. To achieve these goals, we design evidence –based treatment programs for our clients and we take responsibility for managing those programs so the rate of progress can be determined routinely. Please feel free to question the protocol as well as the rate of progress at any time.

A critical factor in successful treatment is the client attendance. While we expect clients to attend all scheduled sessions, we understand emergencies do occur. In these situations, we request you call the office to cancel your session at 865-974-5451. If emergencies require you to miss more than two scheduled sessions, we may temporarily dismiss you from treatment until a time you can return on a regular schedule. If this occurs, you will be given priority for placement when vacancies in treatment allow. We are here to support your success in treatment

During the semester breaks, we are required to establish new schedules for our clients, those who have attended regularly will receive first priority for placement in treatment.

Nola T. Radford, Ph.D. CCC-SLP, BCS-F

Director of Clinical Education and Research

THE UNIVERSITY of TENNESSEE UT
HEALTH SCIENCE CENTER
Department of Audiology and Speech Pathology

Hearing and Speech Center (UTK Campus)
1600 Peyton Manning Pass
Knoxville, TN 37996-2500
Phone: 865-974-5451
FAX: 865-974-4639

ELECTRONIC COMMUNICATION REQUEST

The Hearing and Speech Center would like to stay in communication with clients during the year. If you would like to receive information via email from our Center, please complete the following form.

If you do not wish to receive emails from our Center please check here and write the patient name below. ☐

Patient name: _____

Patient date of birth: _____

Signature: _____ Date: _____

Email address (print): _____

I wish to receive the following (check all that apply):

___ UT Department of Audiology and Speech Pathology updates

___ Research Opportunities

___ Fundraising/Donation Opportunities

___ Patient Satisfaction Survey (you may be asked to complete this at the end of your visit)

Please tell us how you learned about UT Hearing and Speech Center?

_____

You may also find us on Facebook at *University of Tennessee Hearing & Speech Therapy.* Join our group today!

Office Use

Chart Number: _____

Financial Agreement

Patient ID Number:

I understand and agree to pay for the speech and language services I receive at The UT Hearing and Speech Center that are not covered by my insurance. I also
Understand that the current fee rates are:

(A): $200.00 for complete speech-language evaluation
(B): $80.00 for each individual speech-language therapy session.
(C):$85.00 for swallowing/feeding therapy

I understand that payment is due at the time services are rendered unless other alternate payment arrangements have been made by the front office staff as follows:

_____The center will file claims for the services with my TennCare/Bluecare Insurance Company and I am responsible for the deductible and copays or co insurance as outlined by my insurance plan at time of service.

_____The center will file claims for the services with my Insurance company and I am responsible for the deductible, copays and coinsurance as outlined by my insurance plan at the time services are rendered.

_____The center will file claims with my Medicare and I am responsible for the deductible and copays or co insurance and any non-covered service as outlined by my Medicare Plan at the time services are rendered.

_____The center will file claims for the services with my insurance company and or bill the remaining balance to Tennessee Early Intervention System.

_____The center has a contract with_____School System for the services received and I am responsible for any services that is not covered by the school contract.

_____I am also aware that The UT Hearing and Speech Center is not in network with United Healthcare and Aetna and that I am responsible for services rendered.

It is my responsibility to inform the Hearing and Speech Center of any changes with my address, phone number and or insurance. I also understand that any changes to this financial agreement affect subsequent charges and that I am responsible for all charges on my account. I authorize the release of information necessary to process all claims for the services rendered at The Hearing and Speech Center. I authorize payment directly to The UT hearing and Speech Center from my insurance policy benefits payable to me and I hereby assign all such policy benefits to the UT Hearing and Speech Center.

Signature of Client _____ **Date** _____

Staff Signature _____ **Date** _____

THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER

General Consent for Care and Treatment Consent

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 are indicating 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 physician 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 health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees (Resident,etc.) as deemed necessary, to perform reasonable and necessary medical 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 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	**Relationship to Patient**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**

THE UNIVERSITY of TENNESSEE HEALTH SCIENCE CENTER

COLLEGE of HEALTH PROFESSION

University of Tennesse
Hearing and Speech Cente
1600 Peyton Manning Pas
Knoxville, TN 3799
Phone: (865) 974-5451
Fax: (865) 974-463

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.

Medications (including any vitamins/supplements)

Name of medication	Dosage (amount & how often)	Method (oral, injection, patch)

Printed Name: _____ **Signature:** _____

Date Completed: _____

Date Updated: _____ **Initials:** _____

Date Updated: _____ **Initials:** _____

Updated: 9/2014, T.V.

THE UNIVERSITY of TENNESSEE HEALTH SCIENCE CENTER

COLLEGE of HEALTH PROFESSIONS

University of Tennessee
Hearing and Speech Center
1600 Peyton Manning Pass
Knoxville, TN 37996
Phone: (865) 974-5451
Fax: (865) 974-4639

University of Tennessee Hearing and Speech Center
Acknowledgment of Receipt of the Notice of Privacy Practices

I have been given a copy of the notice of Privacy Practices (September, 2013) 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 that the University of Tennessee Hearing and Speech Clinics are not required to agree to the restrictions requested. I understand that I may revoke this Acknowledgment in writing, except to the extent that the organization has already taken action in the reliance thereon.

Signature of Client or Legal Representative:_____

Date:_____

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COLLEGE of HEALTH PROFESSIONS

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Name of medication	Dosage (amount & how often)	Method (oral, injection, patch)

Printed Name: _____ **Signature:** _____

Date Completed: _____

Date Updated: _____ **Initials:** _____

Date Updated: _____ **Initials:** _____

Updated: 9/2014, T.V.

THE UNIVERSITY of TENNESSEE
HEALTH SCIENCE CENTER
Department of Audiology and Speech Pathology

HEARING & SPEECH CENTER
CONSENT TO *RECEIVE* INFORMATION

Date of Request _____

Patient Name _____ **Date of Birth** _____

Parent Name (if patient is under 18 yrs) _____

I hereby authorize The University of Tennessee Hearing and Speech Center to *RECEIVE* the following information via mail, email, fax, and/or telephone.

- ☐ **Medical records** (reports, video, images, etc.)
- ☐ **Evaluation Reports** **re:**_____
- ☐ **Treatment Reports** **re:**_____
- ☐ **Academic records**
- ☐ **Other** (describe) _____

Receive from (list agency/program/physician) _____

Address_____ **City** _____ **State** _____ **Zip** _____

Phone _____

Patient/Parent Signature _____ **Date** _____

****

☐ **I do not wish for any information from outside agencies be sent to the UT Hearing and Speech Center at this time.**

Patient/Parent Signature _____ **Date** _____

NOTE: This release is good for **one year** from the date signed.

Rev 1/2017

THE UNIVERSITY of TENNESSEE
HEALTH SCIENCE CENTER
Department of Audiology and Speech Pathology

HEARING & SPEECH CENTER
CONSENT TO *RELEASE* INFORMATION

Date of Request _____

Patient Name _____ **Date of Birth** _____

Parent Name (if patient is under 18 yrs) _____

I hereby authorize The University of Tennessee Hearing and Speech Center to *RELEASE* the following information and via mail, email, fax, and/or telephone.

☐ **Evaluation Reports**

☐ **Treatment Reports**

☐ **Other** (describe) _____

Release to (list agency/program/physician) _____

Address _____ **City** _____ **State** _____ **Zip** _____

Phone _____

Patient/Parent Signature _____ **Date** _____

****

☐ I do not wish for any information from the UT Hearing and Speech Center to be sent to any outside agencies at this time aside from the referring physician.

Patient/Parent Signature _____ **Date** _____