Pediatric Case History Form

Welcome to Audiology Services of West Virginia! We strive to do our best to help you reconnect to your world and communicate with your friends and loved ones through hearing. Please fill out this form completely. If you have questions, please ask our Patient Care Coordinator!

PATIENT INFORMATION

Today's Date: _____

I prefer to be called: _____

First Name: _____ Last: _____ MI: ___

Guardian's Name(s): _____

DOB: ____/____/____ ☐ Male ☐ Female

SSN: _____-____-_____

Home Address: _____

_____

CITY STATE ZIP

Preferred Phone #: _____ (Home/Cell/Work)

Other Phone #: _____ (Home/Cell/Work)

Email Address: _____

Preferred Contact Method (circle one): Email Cell# Wk# Hm#

Best times to reach you? _____

School: _____

Other family members seen by us? _____

Child's Interests: _____

_____

What are your goals for today's appointment?

_____

_____

_____

What questions do you have for your provider today?

_____

_____

_____

Does your child have a Primary Care Physician? ☐YES ☐NO

Physician's Name: _____

Phone #: _(____)_____ Last Visit: ___/__/_____

Has your child's hearing been tested? ☐Yes ☐No

If yes, date & location of last exam: _____

Has your child been diagnosed w/ hearing loss? ☐Yes ☐No

REFERRAL INFORMATION

We like to know how our patients found us! Please mark all that apply

☐ Physician ☐ Friend / Co-worker ☐ Facebook Page

☐ Audiologist ☐ Health Plan / HMO ☐ Twitter

☐ Internet ☐ Family Member ☐ TV Commercial

☐ Voc. Rehab. ☐ Hospital Referral

☐ Yellow Pages ☐ Our Website

☐ Other: _____

☐ Name of Person Who Referred You: _____

PARENT INFORMATION

Parent/Guardian Name: _____

Relationship to Patient: _____

DOB: ____/____/_____ Best Phone #: _____

Billing Address: _____

_____

INSURANCE INFORMATION

Person Responsible for Account: _____

Name of Insured: _____

DOB of Policy Holder: ___/___/___ Relation: _____

Please provide our Patient Care Coordinator with a copy of your most recent insurance cards. If you are NOT the primary insured, please be sure to include the primary insured's name and information in the provided area above for billing purposes. *Services may be denied or extra charges may apply if insurance information is not presented.*

EMERGENCY CONTACT

Name: _____

Relation: _____

Preferred Phone #: _(___)_____

Other Phone #: _(___)_____

MEDICAL INFORMATION

Do you have concerns for your child's hearing? ☐YES ☐NO
If Yes please explain: _____
Age of mother at child's birth: _____
Child's birth weight: _____ Length of Pregnancy: _____

Mother's Prenatal History: (please check all that apply)

☐ RH Incompatibility
☐ CMV
☐ Rubella/Measles
☐ Medication Taken
☐ Maternal Illness
☐ Toxemia
☐ Substance Abuse
☐ Infections
☐ Lack of Oxygen
☐ Communicable Disease
☐ Venereal Disease/STD
☐ Other: _____

Please check any conditions that occurred during childbirth:

☐ Caesarean
☐ Lack of Oxygen
☐ Medication given to Mother
☐ Medication given to Child
☐ Congenital Abnormality
☐ NICU Stay Required
☐ Oxygen Administered
☐ Jaundice

Please Explain: _____

Child's Hearing History: (please check all that apply)

☐ Medical/Surgical treatment for ears?
☐ PE Tubes If Yes, what age: ____
☐ Family History of Hearing Loss
☐ Child complaining of pain or fullness in ears?
☐ Exposure to loud noises? (i.e. gunfire, explosions)
☐ History of Ear Infections If Yes, date of last episode: _____
☐ Fall/lose balance easily
☐ Has the child reported hearing noises in ear(s)?

Please Explain any marked: _____

Child's Health History:
(please check all the apply & list date of occurrence)

☐ Measles _____
☐ Scarlet Fever_____
☐ Sinusitis _____
☐ Seizures _____
☐ Head Injury _____
☐ Tonsillitis _____
☐ Encephalitis_____
☐ Other _____
☐ Chicken Pox _____
☐ Frequent Colds _____
☐ Draining Ears _____
☐ Meningitis _____
☐ High Fever _____
☐ Mumps _____
☐ Flu _____

Please List current Medications your child is prescribed/taking:

_____

_____

Did your child meet gross motor milestones (ex: walking?)

☐YES ☐NO If No, Please Explain: _____

Is your child enrolled in speech, occupational, or physical therapy?

☐YES ☐NO If Yes Please Explain: _____

Is your child meeting speech/language milestones?

☐YES ☐NO If No, Please Explain: _____

Age at child's first word: _____ Number of words used: _____

Does your child follow multi-step directions? ☐YES ☐NO

Other Concerns: _____

_____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidences and it is my responsibility to inform this office of any changes to my medical or personal status as it pertains to these records. I authorize this practice to perform any necessary Audiological services that I may need during diagnosis and treatment with my informed consent and, when appropriate, to bill my insurance company for services. I accept full responsibility for charges incurred as a result of Audiological services or remaining balances following insurance remittance and agree to pay balances and/or any legal fees or court costs associated with collecting any balance due.

_____ _____
Signature Date

Payment for services is due in full at the time of the service unless prior arrangements have been approved.

Acknowledgement of Receipt of Notice of Privacy Practices

This company's Notice of Privacy Practices may be found online at www.hearwv.com or in hard copy.

I attest that I have been given the opportunity to receive a copy of this office's Privacy Practices or have been directed to a copy of these practices that may be accessed either in hardcopy or electronic copy. Please notify the office's Patient Care Coordinator if you would like a printed copy of Privacy Practices.

_____ _____
Signature Date

Thank you for completely filling out this form for us today. It will allow us to more effectively help you to make decisions about your hearing healthcare. If you have any questions, at any time, please feel free to ask! We are happy to help.

AUDIOLOGY SERVICES of West Virginia

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Carlee A. Squires, AuD
R. Michael Squires, AuD

Patient Financial Agreement

Audiology Services of West Virginia, LLC strives to provide the most comprehensive and satisfactory Hearing and Balance Healthcare services in the Mid-Ohio Valley.

- As a courtesy, we will be happy to bill your current insurance and co-insurance for services; **however, all charges, regardless of insurance of insurance coverage are the patient's responsibility.** Our clinic contracts with most insurance companies. It is your responsibility to contact your insurance company prior to services to investigate in-network eligibility. Signing this document gives us permission to bill your insurance company for services you receive.

- It is important to remember that your individual contract with your insurance company determines co-pays, deductibles, etc. and how your insurance will pay for covered services. We make every effort to bill each visit with the proper diagnosis and procedure codes per national billing and coding guidelines as well as requirements for each insurance company. **Please understand that we cannot make exceptions to our coding practices due to federal and state legal compliance concerns, and we are unable to bill for services other than those documented in your medical records in our clinic.**

- Health insurance is required prior to services being rendered. If no health insurance information is provided at the time of service, you may be denied services until your insurance information can be documented or you may opt to pay out-of-pocket for services. **It is your responsibility to ensure that insurance information is up-to-date and in effect. If Insurance information provided to our clinic at the time of service is, at any time, found to be incorrect or not in effect, you will be billed for any services provided**

- You may opt at any time to pay out-of-pocket rates for services that are typically billed to insurance. Charges for services not covered by insurance are due at the time of service. If you have a question if services are covered or not please ask prior to the administration of the service.

Out-of-pocket Rates for Services

- Audiological Evaluation - $100
- Hearing Screening - $50
- All Vestibular Services - $150/hour
- TruHearing/EPIC Office Visit - $65

*NOTE: services not typically covered by insurance will not be billed at these rates.

- It is important to strictly enforce this policy of financial obligation. **All co-pay, self-pay, and other payments are due at the time of service and may be paid by cash, check, credit, or debit cards. We also offer financing through several institutions. Please ask for more information about financing.**

- Fees may be assessed for no-shows and cancellation of appointments without 24 hours prior notice for any office visit. **These fees are the responsibility of the patient and cannot be filed with your insurance company. Cancellation messages may be left on the company answering machine for your convenience but must be 24 hours in advance of scheduled appointment time to avoid fees.**

No Show / Cancellation Fees

- Cancellation without prior notice - $25
- 1st No Show - $25
- 2nd No Show - $50
- 3rd No Show - $75

- All charges are due within 30 days of invoice date. Second notices will be sent if not paid on due date. **All charges not paid within 90 days will be processed by our collections agency.**

I have read and understand the above information and agree to comply with these policies.

_____ _____

Print Name Date

_____

Signature