dr. Tonya Steed, AuD
AUDIOLOGIST

Pediatric Case History

Child's Full Name: _____ Date: _____
Nickname: _____ Birthdate: _____
Gender: ☐ Male ☐ Female Preferred Hand for Writing: _____ Age: _____ ☐ Years ☐ Months
Parents Names: _____ Marital Status: _____
☐ Birth Parents ☐ Foster Parents ☐ Adoptive Parents ☐ Guardians
Parents Occupation(s): _____
Home Address: _____
Home Phone Number: _____ Cell Phone Number: _____
Email Address: _____
Preferred method of communication: ☐ Home ☐ Cell ☐ Email
Siblings Names and Ages: _____ ☐ Only Child
Who lives in the home with the child? _____
Diagnosis (if known): _____
Primary Care Physician: _____ Phone Number: _____
Referral Source: _____ Phone Number: _____
How did you hear about Dr. Steed? _____

Birth History

Adopted: Birth history is Limited ☐ Unknown ☐
Birth Hospital: _____ Gestational Age at Birth (length of pregnancy): _____ Weeks
Birth Weight: _____ ☐ Grams ☐ Pounds
Apgar scores normal? ☐ Yes ☐ No If not, what were the scores? _____
Prenatal difficulties? ☐ Yes ☐ No If yes, please describe: _____
Delivery difficulties? ☐ Yes ☐ No If yes, please describe: _____
_____
NICU (Special Care) stay after birth? Yes ☐ No ☐ If yes, how long? _____
Ventilation required? Yes ☐ No ☐ If yes, how long? _____
Any significant infections? Yes ☐ No ☐ If yes, please describe: _____
Medications given? Yes ☐ No ☐ If yes, please list: _____
Treatment for Jaundice? Yes ☐ No ☐ If yes, please describe: _____
Any scars or physical abnormalities of the head or ears? 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 appropriate column:

	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: _____			

Has your child been diagnosed with any of the following developmental or learning disorders? Please check Yes or No to the right of each condition:

	No	*Yes*		*No*	*Yes*		*No*	*Yes*
Anxiety			Bipolar Disorder			Obsessive/Compulsive		
Attention Deficit			Depression			Reading Disability		
Aspergers			Dyslexia			Sensory Integration		
Autism			Language Disorder			Visual Processing		
Behavior Disorder			Learning Disability			Other: _____		

If yes, please explain: _____

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: _____

Hearing History

Was your child's hearing screened at birth? ☐ Yes ☐ No If yes, what were the results: _____

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

Do any immediate family members have the following conditions:

Condition	Yes	No		Yes	No
Anxiety			Dyslexia		
Attention Deficit Disorder (ADD/ADHD)			Hearing Loss from Birth		
Auditory Processing Disorder (APD)			Language Disorder		
Autism/Aspergers Spectrum Disorder			Learning Disability		
Bipolar Disorder			Obsessive/Compulsive Disorder (OCD)		
Cognitive Deficits			Sensory Integration (SI) Disorder		
Depression			Other: _____		

If yes, please explain: _____

_____

Developmental History

Do you have any concerns about your child's physical or mental development? _____

Are you child's developmental milestones known? ☐ Yes ☐ No. If no, skip the next question.

Age at which the following developmental milestones were reached:

Hold head erect _____ Crawl _____ Sit unsupported _____

Say first word _____ Walk alone _____ Toilet trained _____

Has your child listened to any language other than English since birth? ☐ Yes ☐ No

If yes, please list: _____

Do you consider your child clumsy? ☐ Yes ☐ No If yes, please explain: _____

Does your child play/interact well with other children? ☐ Yes ☐ No If no, please explain: _____

_____

_____

Social Skills

Social difficulties (check all that apply): ☐ None

☐ Impulsive ☐ Frustrations ☐ Distressed by loud sounds ☐ Disobedient

☐ Destructive ☐ Nightmares ☐ Difficulty making/keeping friends ☐ Difficulty sleeping

☐ Temper tantrums ☐ Fearful ☐ Over-sensitivity to touch, light, or fabrics (circle all that apply)

☐ Aggressive ☐ Shy ☐ Thumb/finger sucking ☐ (other) _____

Please list any previous/current services performed:

Evaluation	*Approximate Date*	*Where/By Who*	*Diagnosis/Recommendations*
Speech/Language			
Occupational Therapy			
Vision Therapy			

Psychological/ Psycho-Educational			
Neuro-Psychological			
Other: _____ _____			

Educational History

Current School: _____ ☐ Home schooled ☐ Private ☐

Public Current Grade Level: _____

Does your child have any academic weaknesses: ☐ N/A

None Reading Science Social Studies
Math Writing Spelling Other: _____

Explain: _____

Is your child enrolled in any current tutoring, therapy or special services in or out of school? (include start dates and frequency)? _____

Does your child have a current IEP? ☐ Yes ☐ No

Please list your child's extra-curricular activities and favorite toys: _____

Learning style (check all that apply): ☐ N/A (for infants and toddlers)

☐ Logical	☐ A planner	☐ Creative	☐ Spontaneous
☐ Analytical	☐ Good sense of time	☐ Intuitive	☐ No sense of time
☐ Sequential	☐ Good fine motor skills	☐ Scattered	☐ Good gross motor skills
☐ Detail oriented	☐ Rule oriented	☐ Disorganized	☐ Thinks outside of the box

Is there anything else about your child's educational needs that we should know? ☐ Yes ☐ No

If yes, please explain: _____

Communication Skills

Communication difficulties (check all that apply): ☐ None

☐ Unclear speech	☐ A need for messages to be repeated	☐ Frustration with communication
☐ Localization difficulties	☐ Auditory sequencing weaknesses	☐ Misinterpretation of messages
☐ Attention weaknesses	☐ Auditory memory weaknesses	☐ (Other)_____

_____

_____

_____

Is there anything else we need to know about your child? _____

_____

_____

_____ _____

Print name of person completing this form Relationship to patient

_____ _____

Signature Date

FINANCIAL POLICY

Updated 3/1/17

Tonya Steed, AuD is out-of-network for all private insurance companies and does not accept Medicaid. Our office does not submit claims to insurance companies. If a parent wishes to file an insurance claim, a detailed superbill with the CPT codes and Diagnosis Codes will be available at the parent's reques..

_____parent initials

Tonya Steed, AuD charges the usual and customary rate for an Auditory Processing Evaluation. ***Full paymenet of $625 is due at the time of service, regardless of out-of-network benefits.***

_____parent initials

Tonya Steed, AuD charges a $150/hr. consultative fee for any time requested to discuss test results or recommendations outside of the scheduled Evaluation/Consultation visit.

_____parent initials

Tonya Steed, AuD will not release the formal report of evaluation findings and recommendations before the check for payment has cleared.

_____parent initials

Please do not hesitate to contact Tonya Steed, AuD regarding questions of billing. We are willing to work with each family to insure a balance between providing therapy services and addressing business issues or concerns.

I have read and understand the above insurance and billing policies.

Signed _____ Date _____

Parent/ Legal Guardian Relationship

CONSENT FOR EVALUATION

I, _____ (caregiver's name), knowing that _____ (child's name) has a need for audiological testing, voluntarily consent to Auditory Processing testing for the aforementioned child by Tonya Steed, AuD. I acknowledge that no guarantee has been made to me as the result of the evaluation.

Signed _____ Date _____

Parent/Guardian Relationship

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient if under 18 years of age.

_____ _____

Please ***print*** name of Guardian Guardian ***signature***.

Your comments regarding Acknowledgements or Consents: _____

_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, CONVEY MEDICAL INFORMATION, CONVEY NEW INFORMATION PERTAINING TO MY CHILD'S DIAGNOSIS, & BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO A THIRD PARTY

Per Tonya Steed, AuD Policy, reports are only sent via secure email to parents. Per parent request, we will send patient reports to ordering physicians and other third parties. If you would like to request us to provide any report to your physician or a third party, please complete the authorization information below. If you would like to provide the information yourself, then leave this form blank.

I, _____, (Name of Patient making Request), hereby authorize **Tonya Steed, AuD**, (hereafter collectively referred to as the "Practice") to use and disclose:

☐ Evaluation Results
☐ Treatment Plan

I acknowledge that this Healthcare Facility, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical records to the party listed below. I have reviewed this Practices Notice of Privacy Practices (NOPP) and have been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify this Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize this Practice to use and disclose verbally or by mail the following types of ***super-confidential information*** as stated in the NOPP (initial where appropriate):

REQUIRED TO COMPLETE:
In accordance with HIPAA Omnibus Rule of 2013, I understand that I need to provide the specifics of this release request:

1. Date of this Request: _____

   Please Release my records to: _____ (Name of Physician)

   ☐ Send Physician a copy of my records to this address: _____
   _____
   _____

2. Please Release my records to: _____ (Name of Therapist)

   ☐ Send Third Party a copy of my records to this address: _____
   _____
   _____

Patient: _____
(Print name)

Patient's Representative _____ Date: _____
(Print name, sign, and describe authority)

OFFICE USE ONLY

Describe what alternative communications were denied this _____ day of _____, 20____