Christa B. Reeves, Au.D.
Audiologist
6720 Jamestown Drive, Alpharetta GA 30005
(770) 744-2451 phone (770) 573-6399 fax

Adult Case History

Patient's Name: _____ Date: _____
Birthdate: _____ Age: _____
Gender: ☐ Male ☐ Female
Home Address: _____
Home Phone Number: _____ Cell Phone Number: _____
Email Address(es): _____
Preferred method of communication: ☐ Home ☐ Cell ☐ Email
What is the reason for today's visit? _____
Diagnosis (if known): _____
Primary Care Physician: _____ Phone Number: _____
Referral Source: _____ Phone Number: _____
How did you hear about Little Listeners? _____

Medical History

Have you had any of the following medical problems? Please check No, Past or Present to the right of the condition:

	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: _____			

If you answered Past or Present to any of the above, please describe and list approximate dates:

_____

_____

Have you been diagnosed with any of the following psychological 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 you answered yes, please explain: _____

_____

Please list any previous testing that has been performed:

Evaluation	*Approximate Date*	*Where/By Who*	*Brief Summary of Results*
Speech/Language			
Occupational Therapy			
Vision Therapy			
Psychological			
Neuro-Psychological			
Other: _____			

Allergies or Dietary Restrictions: _____

Surgical History: _____

Have you had any scans, x-rays, MRI's or special tests? ☐ Yes ☐ No

If yes, please list and provide results: _____

Current Medications and Dosages (Supplements, OTC and Prescription):

_____

Other Medical Concerns: _____

Educational/Occupational History

Current School/Occupation: _____

Highest Completed Grade Level/Degree: _____

Do/Did you have any academic weaknesses:

None Reading Science Social Studies

Math Writing Spelling Other: _____

Explain: _____

Are you currently enrolled in any therapy or academic tutoring? (include start dates and frequency)?

_____

Learning style (check all that apply):

☐ 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

Communication/Social Skills Difficulties

Communication difficulties (check all that apply): ☐ None

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

_____

Social difficulties (check all that apply): ☐ None

☐ Impulsive ☐ Frustrations ☐ Distressed by loud sounds ☐ Difficulty sleeping
☐ Aggressive ☐ Shy ☐ Over-sensitivity to touch, light, or fabrics (circle all that apply)
☐ (other) _____

Hearing History

Do you have concerns about your hearing? ☐ Yes ☐ No If yes, please explain: _____

Do you 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? _____

Family History

Do any immediate family members have any of the following conditions:

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

If yes, please explain: _____

Is there anything else we need to know about you? _____

_____

_____ _____ _____

Print name Signature Date

Christa B. Reeves, Au.D.
Audiologist
6720 Jamestown Drive, Alpharetta GA 30005
(770) 744-2451 phone (770) 573-6399 fax

NAME:_____ DATE OF BIRTH:_____

FINANCIAL POLICY

Updated 12/16/2013

Christa B. Reeves, AuD. operates under the business name, Little Listeners, LLC. Little Listeners, LLC is out-of-network for all private insurance companies. Little Listeners, LLC charges the usual and customary rate for assessment and therapy services. Little Listeners, LLC is an In-Network provider for Medicaid, Amerigroup, Peachstate and Wellcare only. We will file out-of-network benefits for private insurance plans by request only and reimbursements will be paid directly to you. ***Full payment is due at the time of service, regardless of out-of-network benefits.*** A copy of your insurance card(s) and driver's license will be required at the beginning of the first session.

_____patient initials

Traditional Medicaid, Katie Beckett Medicaid, SSI Medicaid, Amerigroup, Peachstate and Wellcare are accepted.Insurance will always be billed first and Medicaid will be billed secondary unless it is the primary source of payment. Prior approvals are usually required for therapy services and some assessments. Therapists will submit for prior approvals based on need. Services will be administered only after approval has been obtained.

_____patient initials

As in all health-care situations, the client-family is always responsible for payment. If a payment plan has been arranged and payment has not been received within 30 days of receipt of the billing invoice, there will be a 10% late fee added. Therapy services may be put on hold or terminated if there is a problem regarding payment. There is a $25 service fee for all returned checks.

_____patient initials

I authorize Little Listeners, LLC to bill me directly for assessment and therapy services rendered to my child. I understand thatout-of-network benefit payments by my insurance company will be sent directly to me by my insurance provider that were intended to cover the assessment and/or therapy services provided by Little Listeners, LLC. I understand that I am responsible for payment for all services up front and that the out-of-network filing benefit is a courtesy of Little Listeners, LLC and not a contractual agreement that my insurance company has with them.

_____patientinitials

Please do not hesitate to contact us regarding questions of billing/payments. We are willing to work with each client 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 _____
Patient Signature

Christa B. Reeves, Au.D.
Audiologist
6720 Jamestown Drive, Alpharetta GA 30005
(770) 744-2451 phone (770) 573-6399 fax

NAME:_____ DATE OF BIRTH:_____

CONSENT FOR TREATMENT

I, _____ (name), knowing I have a diagnosis requiring auditory therapy treatment, voluntarily consent to such care by the therapist doing business for Little Listeners, LLC as may be beneficial in the professional judgment of this therapist. I consent to care and treatment that falls within the scope of practice as defined by the State of Georgia for each discipline. I understand that treatment will involve physical participation on the part of the patient which may involve risks of injury.I am responsible for making my therapist aware of any changes in my physical or mental status. I acknowledge that no guarantee has been made to me as the result of evaluation and/or treatment.Little Listeners, LLC is a teaching facility and supervised students or volunteers may participate in your treatment session.

Signature: _____ Date _____

CONSENT TO EXCHANGE INFORMATION

I authorize Little Listeners, LLC to release or communicate necessary and pertinent information to physicians, case managers, and insurance companies for myself.Approved information may be given to, received from, and discussed with the following people directly related to my care. Approved information includes written documentation and/or verbal discussion.
Other Therapists: _____Facility Name: _____

Please list any others:_____

Signature: _____Printed Name_____Date _____

NOTICE OF PRIVACY POLICY

I have read, understand, and agree to the Little Listeners Notice of Privacy Policy. I understand I may request a copy of this policy at any time. I consent to receive communication regarding my therapy via (circle all that apply) phone messages at home or cell phone, email address: _____

Signature: _____Printed Name_____Date _____

MEDIA RELEASE

I ___ do / ___ do not consent to the use of photos or videos of myself to be used by Little Listeners, LLC on social media or in marketing materials for the purposes of business development and/or business marketing.

Signed _____Printed Name_____Date _____