LittleListeners
Helping young minds learn to listen

Pediatric Case History

Child's Full Name: _____ Date: _____
Nickname: _____ Birthdate: _____
Gender: ☐ Male ☐ Female 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(es): _____
Preferred method of communication: ☐ Home ☐ Cell ☐ Email
Siblings Names and Ages: _____ ☐ Only Child
Who lives in the home with the child? _____
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? _____

Insurance Information (Out-of-Network)

Primary Insurance Company: _____ Person Insured: _____
Insurance Phone Number: _____ Policy Number: _____ Group Number: _____
Medicaid Number: _____ Effective Date: _____
Medicaid CMO Carrier: _____ CMO: ID Number: _____
(Traditional and PeachState only)

Birth History

Birth Hospital: _____ Gestational Age at Birth (length of pregnancy): _____ Weeks
Birth Weight: _____ ☐ Grams ☐ Pounds
Small for Gestational Age (SGA)? ☐ Yes ☐ No
Low birth weight? ☐ Yes ☐ No
Abnormal weight loss after birth? ☐ Yes ☐ No
Apgar scores normal? ☐ Yes ☐ No If not, what were the scores? _____
Prenatal difficulties? ☐ Yes ☐ No If yes, please describe: _____
Medications taken during pregnancy? ☐ Yes ☐ No
If yes, please list: _____
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? 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 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:

_____

_____

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: _____

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

_____

Other Medical Concerns: _____

_____

Hearing History

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

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

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 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 your child? _____

_____

_____

_____

_____ _____

Print name of person completing this form Relationship to patient

_____ _____

Signature Date

FINANCIAL POLICY
Updated 12/16/2013

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 requestonly 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.

_____parent initials

Traditional Medicaid, Katie Beckett Medicaid, SSI Medicaid, Amerigroup, Peachstateand 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.

_____parent 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.

_____parent initials

I authorize Little Listeners, LLC to bill me directly for assessment and therapy services rendered to my child. I understand that out-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.

_____parent initials

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 _____
Parent/ Legal Guardian Relationship

CONSENT FOR TREATMENT

I, _____ (caregiver's name), knowing that _____ (child's name) has a diagnosis requiring audiological testing and/or hearing therapy, voluntarily consent to such care for the aforementioned child by the therapist doing business for Little Listeners, LLC. as may be beneficial in the professional judgment of this child's 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. You are responsible for making your therapist aware of any changes in your child's 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 child's treatment session.

In my absence, I consent that_____ (child's name) may receive therapy under the care of:
_____.
(List all caregivers, teachers, daycare providers, etc. that may be present during therapy in your absence.)

Signed _____ Date _____
Parent/Guardian Relationship

MEDIA RELEASE

I ___ do / ___ do not consent to the use of photos or videos of myself or my child 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 _____

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 / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

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

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

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

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

□ Phone Message
□ Text Message
□ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

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 Little Listeners Policy, we only send reports via secure email to parents. Under certain circumstances, 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 or other therapy information 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 **Little Listeners**, (hereafter collectively referred to as the "Practice") to use and disclose:

☐ Therapy Treatment Plan
☐ Assessment Results

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, by mail, fax or encrypted email, 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 Third Party)

   ☐ 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____