# University of Maryland
# Hearing and Speech Clinic
# Pediatric Audiological Case History

**Insurance: We are currently only accepting the following insurances**

- **Medicare/Medicaid**
- **CareFirst BlueCross BlueShield (BlueChoice, Regional Preferred Provider, and GHMSI)**
- **United Healthcare**

## I. IDENTIFICATION

Patient Name: _____ Gender: ___ Age: ___ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone number: _____ Alt Phone: _____

Referred by: _____

Reason for referral: _____

Pediatrician name: _____ Address: _____

Phone number: _____ _____

Parent/Guardian Information

| Parent #1 | Parent #2 |
|---|---|
| Name: | Name: |
| Address: | Address: |
| | |
| Phone: | Phone: |
| Email: | Email: |

Child resides with: ☐ Parent #1 ☐ Parent #2 ☐ Both parents

## II. HEARING LOSS HISTORY

Do you have any concerns about your child's hearing? Yes ◯ No ◯

If yes, explain _____

_____

Did your child pass their newborn hearing screening? Yes ◯ No ◯

Has your child had any previous hearing tests? Yes ◯ No ◯

If yes, please indicate where hearing test(s) was administered, date of test(s), results, and recommendations _____

_____

_____

_____

Is there a family history of hearing loss? Yes ◯ No ◯

If yes, please indicate relationship of family member to patient, age of hearing loss identification, and degree of hearing loss _____

_____

_____

## III. BIRTH HISTORY

Length of pregnancy: _____ Birth Weight: _____

Any complications with delivery? Yes ◯ No ◯ If yes, please explain: _____

_____

Was your child admitted to the neonatal intensive care unit (NICU) after birth? If yes, why? For how long? _____

_____

## IV. DEVELOPMENTAL BEHAVIOR

*Motor*

Ages of: Sitting up: _____ Crawling: _____ Walking: _____

*Speech/Language*

Ages of: Babble: _____ First word: _____ Short Sentences: _____

Does your child use understandable speech? Yes ◯ No ◯ If no, please describe: _____

_____

## V. MEDICAL HISTORY (check all that apply)

Ear Aches ☐ Ear Infections ☐ Draining Ears ☐ PE Tubes ☐ Asthma ☐

Measles ☐ Mumps ☐ Chicken Pox ☐ Tonsils/Adenoids Removed ☐

Allergies ☐ Meningitis ☐ Encephalitis ☐ Seizures ☐

Other ☐ _____

Please explain any checked items: _____

_____

Does your child have any special behavior problems? Yes ◯ No ◯

If yes, please describe _____

_____

_____

## VI. EDUCATIONAL HISTORY

Current school and grade: _____

_____

Is schoolwork satisfactory? Yes ◯ No ◯ If no, please describe _____

_____

Has your child received special help of any kind? Yes ◯ No ◯

If yes, please describe _____

_____

Has the teacher expressed concerns? Yes ◯ No ◯ If yes, please describe _____

_____

Additional comments or information you would like to share: _____

_____

_____

_____

_____

Information provided by:_____

**Insurance Information:**

Policy Holder Name: Date of Birth:

Relationship to patient:

Employer Name:

Employer Address:

Insurance Company:

Group ID#: Insurance ID#:

Insurance Address: Phone #:


## HEARING AND SPEECH CLINIC
## Student Involvement, Collection of Video, and Research Contact Consent/Waiver Form

The Hearing and Speech Clinic is a student training facility. As such:

1. Services may be provided by students who are working towards their Master's degree in speech-language pathology or their Doctoral degree in audiology. These students are closely supervised by experienced speech-language pathologists and audiologists, who are faculty members of the Department of Hearing and Speech Sciences, certified by the American Speech-Language and Hearing Association (ASHA) and licensed by the Board of Examiners of the State of Maryland.
2. Your information may be used for educational or training purposes, but will be kept confidential.
3. Recordings of sessions may be taken for training purposes. These videos are not considered part of your medical record, and may be destroyed once no longer useful for training purposes.
4. Authorized students may have access to your medical files.

By signing below, I acknowledge that I have read, understand, and agree to the above.

_____ _____
Signature of patient or personal representative Date

_____
Printed name of patient or personal representative and his/her relationship to patient

In addition to being a training facility, the Hearing and Speech Clinic is also associated with the Department of Hearing and Speech Sciences, whose mission includes not only clinical training and clinical services, but also research. We would like for students and faculty to be able to review your records for potential study eligibility, and to contact you about research opportunities for which you might be eligible and interested. You may decline to participate in research at any time, and this will have no impact on your treatment in our clinic. Please sign here if you allow our faculty and students to review your files.

_____ _____
Signature Date

## HEARING AND SPEECH CLINIC

**Patient Contact Preferences**

Name of Patient: _____

I would prefer to be contacted for appointment reminders, etc. via the following mechanisms:

- ☐ Email: _____
  *(please note that email is not a secure form of contact)*
- ☐ Phone: _____
  - ☐ You may leave a voicemail message at this number
  - ☐ You may leave a message with another individual at this number

_____ _____
Signature of patient or personal representative Date

_____
Printed name of patient or personal representative and his/her relationship to patient


## ACKNOWLEDGEMENT OF RECEIPT
## HEARING AND SPEECH CLINIC NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the University of Maryland Hearing and Speech Clinic's Notice of Privacy Practices.

_____ _____

Printed Name Date

_____

Signature

_____

Relationship to Patient

.....

**FOR INTERNAL USE ONLY**

__ Client declined to provide signature for acknowledging receipt of privacy practices

_____

Clinic Staff Signature and Date

__ Client was not able to provide signature for acknowledging receipt of privacy practices

_____

Clinic Staff Signature and Date

**UNIVERSITY OF MARYLAND HEARING AND SPEECH CLINIC**

**NOTICE OF PRIVACY PRACTICES (Short Version)**
As Defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCUSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

## I. CLINIC'S COMMITMENT TO YOUR PRIVACY

The University of Maryland Hearing and Speech Clinic (Clinic) is dedicated to maintaining the privacy of your protected health information (PHI). PHI is individually identifiable health information about you that relates to your past, present or future physical or mental health or other condition, as well as any related health care services. This Notice of Privacy Practices (NOPP) provides you with the following important information: our obligations concerning your PHI; how the Clinic may use and disclose your PHI; and your rights with regard to your PHI. **A longer version of this NOPP is available on the Clinic's website and the Clinic will provide a hard copy upon request.**

## II. UNIVERSITY STUDENTS

HIPAA requirements for PHI generally exclude student health information, but the confidentiality of such information is protected under the federal Family Education Rights and Privacy Act (FERPA), Maryland state law, and/or University Policy, as applicable. The Clinic recognizes the need for confidentiality and privacy with respect to student health information, and will use, disclose and otherwise treat your health information accordingly, following the requirements of applicable law and University policy (see Section IV below).

## III. NON-STUDENTS

***A. Clinic's Obligation.*** Federal and state laws require that the Clinic maintain the privacy of your PHI. By complying with these laws, the Clinic is required to provide you with this notice regarding its privacy practices, its legal duties, and your rights concerning your PHI. Except for student records and certain records the University creates or receives in its role as an employer, this NOPP applies to all records containing your PHI that are created or retained by the Clinic. A copy of the NOPP is posted in a visible location in the Clinic waiting room at all times, and you may request a copy of the NOPP at any time.

***B. How The Clinic Uses And Discloses Your PHI.*** This paragraph describes, in general terms, the different ways the Clinic may use and disclose your PHI; it does not cover all possible uses and disclosures. The Clinic may use and disclose your PHI (1) to provide treatment and related health care services to you; (2) to bill and collect payment for the services and items you receive; (3) in connection the Clinic's health care operations, including administrative, financial, and legal activities; (4) to third-party business associates (e.g., billing services); (5) for health related services, such as recommending treatment alternatives; (5) to individuals involved in your care, unless you object; (6) under limited circumstances, for research purposes in accordance with applicable law and University policy; (7) when required or allowed by law; and (8) with your written authorization. For further information or if you have questions, please consult with the Clinic Directors (see below).

## IV. YOUR RIGHTS REGARDING YOUR PHI

***A. Non-Students.*** You have the following rights regarding the your PHI, and you may request any of the following: (1) confidential communication of your PHI in the manner of your choosing; (2) restriction on communications with certain individuals otherwise permitted by law to inspect your PHI; (3) inspection of records containing your PHI; (4) copies of your records; (4) amendments to your PHI if you believe the information is incorrect or incomplete; (5) a list of disclosures we have made of your PHI; and (6) a copy of this NOPP.

***B. University Students.*** University students have similar rights regarding their health information, including the rights to request confidential communications, restrictions on use or disclosure, inspection and copies, amendments, accounting of disclosures, and copies of this Notice. Those rights may, however, be implemented in different ways under FERPA, Maryland law, and/or University policy, as applicable. If you have questions about your rights regarding your health information, please contact the Clinic Directors (see below).

***C. COPIES OF MATERIALS.*** You have a right to all of your medical records. Written authorization is required; the Clinic's records release form is available from the Clinic office. The Clinic can fax records or provide them in paper form; for the latter, the Clinic will charge $0.25/page if the records are more than 5 pages.

## V. IMPLEMENTATION, QUESTIONS, AND COMPLAINTS

***A. Implementation.*** This NOPP provides a general overview of our privacy practices. This NOPP and our privacy practices are implemented in accordance with applicable University policies and procedures and the requirements of HIPAA and other federal and Maryland laws, as applicable.

***B. Complaints.*** If you believe your privacy rights have been violated, you may file a complaint with the Clinic. All complaints must be submitted in writing. We will not retaliate against you in any way if you file a complaint with us.

**VI. CONTACT INFORMATION.** If you have any questions regarding this Notice or our health information privacy practices, please contact:


Nicole Nguyen, Au.D., CCC-A
Director of Audiology Services
nknguyen@umd.edu
(301) 405 – 4221

Colleen Worthington, M.S., CCC-SLP
Director of Speech-Language Services, Clinic HIPAA Privacy Officer
ckworth@umd.edu
(301) 405 – 4238


# HEARING AND SPEECH CLINIC
# AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

1. Authorization

   I authorize the **University of Maryland Hearing & Speech Clinic** to use and disclose the protected health information described below to: Patient _____

   (include address) _____

   Additional Name/ Agency: _____

   (include address): _____

2. Effective Period

   This authorization for release of information covers the period of healthcare from (check one):

   ☐ a. All periods until the present date

   ☐ b. All past, present, and future periods

3. Extent of authorization

   ☐ a. I authorize the release of my complete health record

   ☐ b. I authorize the release of specific information: _____

   _____

4. This medical information may be used by the person I authorize to receive it (listed above) for medical treatment or consultation, billing or claims payments, or other purposes as I may direct.
5. This authorization shall be in force and effect until such time as it is revoked.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of patient or personal representative Date

_____

Printed name of patient or personal representative and his/her relationship to patient

# HEARING AND SPEECH CLINIC
# AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION

(Required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

1. Authorization

   I authorize the **University of Maryland Hearing & Speech Clinic** to obtain protected health information (described below) from:

   Name: _____ Name: _____

   Address:_____ Address:_____

   _____ _____

   Phone:_____ Phone: _____

2. Effective Period

   This authorization for release of information covers the period of healthcare from (check one):

   ☐ a. All periods until the present date

   ☐ b. All past, present, and future periods

3. Extent of authorization

   ☐ a. I authorize the release of my complete health record

   ☐ b. I authorize the release of specific information: _____

   _____

4. This medical information may be used by the **University of Maryland Hearing & Speech Clinic** for medical treatment or consultation, billing or claims payments, or other purposes as I may direct.
5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of patient or personal representative Date

_____

Printed name of patient or personal representative and his/her relationship to patient

UNIVERSITY OF MARYLAND
Hearing & Speech Clinic

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0110 Lefrak Hall
College Park, Maryland 20742
301.405.4218 TEL 301.314.2023 FAX
www.hespclinic.umd.edu

**Notification of Use of Protected Health Information for Fundraising Purposes**

We hope you appreciate the wonderful service you receive from our clinic! We would like to be able to reach out to you in the future both to evaluate your experiences here, and to be a supporter of the clinic. This would allow us to continue providing these valuable services to others in the community who need them.

With that in mind, this form is a courtesy notification to inform you that the administrative staff of the University of Maryland Hearing and Speech Clinic within the Department of Hearing and Speech Sciences and associated development officers of the College of Behavioral and Social Sciences may use your contact information (which constitutes protected health information) for fundraising purposes **in support of the University of Maryland Hearing and Speech Clinic ONLY.**

**The health information that we may use for fundraising purposes includes:**

- Patient demographic data (name, address, phone/email, date of birth, age, gender, etc)
- Dates of patient services
- General type of department from which the patient/client received services (Speech or Hearing)
- Information about the clinical faculty who supervised your services

This information will only be used to identify and contact you regarding opportunities to support the University of Maryland Hearing and Speech Clinic.

**The health information that we will not use or disclose are as follows:**

- Health insurance status
- Outcome information
- Diagnosis
- Nature of services
- Treatment

If you do not wish to receive any fundraising information from the University of Maryland Hearing and Speech Clinic, it is your right to opt out of any and all solicitations. If you wish to opt out, please check to box below and provide your name and date; otherwise thank you for your time and consideration.

☐ I do NOT wish to receive fundraising information from the University of Maryland Hearing and Speech Clinic.

Printed Name: _____

Signature: _____ Date: _____