HEAR Center
301 East Del Mar Boulevard, Pasadena, CA 91101
Phone: (626) 796-2016 Fax: (626) 796-2320
www.hearcenter.org

SPEECH AND LANGUAGE EVALUATION

CHILD'S NAME: _____ DATE OF BIRTH: _____ AGE: _____

PARENT/GUARDIAN'S NAME: _____ RELATIONSHIP TO CHILD: _____
TODAY'S DATE: _____ REASON FOR YOUR APPOINTMENT: _____

FAMILY PROFILE: (Please list all persons and siblings living in the home)

Relationship to Child	Name	Age

LANGUAGES SPOKEN TO THE CHILD: _____
LANGUAGE BEST UNDERSTOOD BY CHILD: _____
WHAT IS YOUR BIGGEST CONCERN AT THIS TIME: _____

BIRTH HISTORY

LENGTH OF PREGNANCY: _____ BIRTH WEIGHT: _____ BIRTH LENGTH: _____
TYPE OF BIRTH: (Please circle) VAGINAL / C-SECTION
COMPLICATIONS DURING PREGNANCY? Yes: ____ No: ____ If so, please describe: _____
_____
INCUBATOR / EXTENDED HOSPITAL STAY? Yes: ____ No: ____ If yes, how long? _____
BREATHING DIFFICULTIES AT BIRTH? Yes: ____ No: ____
WAS OXYGEN GIVEN? Yes: ____ No: ____
OTHER DIFFICULTIES DURING PREGNACNY / AT BIRTH: _____
_____

CHILD'S HEALTH HISTORY

ALLERGIES: _____ CONVULSIONS: _____ HIGH FEVERS: _____
ANY SERIOUS ILLNESSES: _____ SYNDROMES: _____
SURGERIES: _____ TONSILS / ADENOIDS: _____

Current Medication(s)	Dosage	Reason

EAR INFECTIONS? Yes: ____ No: ____ HOW MANY? _____ TREATMENT: _____
HEARING LOSS? Yes: ____ No: ____
DESCRIBE LOSS: (Please circle) MILD / MODERATE / SEVERE / PROFOUND / SENSORINEURAL / CONDUCTIVE
DOES THE CHILD WEAR HEARING AIDS? Yes: ____ No: ____ SINCE WHAT DATE? _____
HOSPITALIZATIONS: Yes: ____ No: ____ DATES: _____ ILLNESS: _____
ACCIDENTS? Yes: ____ No: ____ TREATMENT: _____
SPECIAL TESTS DONE: (EEG, EKG, etc…) _____
DOES THE CHILD WEAR GLASSES? Yes: ____ No: ____ SINCE WHAT DATE? _____

CHEWING / SWALLOWING PROBLEMS: Yes: ____ No: ____ If yes, please describe: _____

SENSITIVE GAG REFLEX: Yes: ____ No: ____ Not Known: ____

SENSITIVITY TO FOOD TEXTURES: Yes: ____ No: ____ Not Known: ____ If yes, please describe: _____

WHAT ARE YOUR CHILD'S FOOD PREFERENCES? _____

CHILD'S PEDIATRICIAN: _____ PHONE NUMBER: _____-_____-_____ Ext.____

FAX NUMBER: _____-_____-_____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

LIST ALL OTHER DOCTORS / AGENCIES WHO HAVE CARED FOR YOUR CHILD:

Date	Name	Address	Phone Number

DEVELOPMENTAL MILESTONES

Please report what age your child did the following:

Sit	
Crawl	
Walk	
Eat Table Food	
Fed Self	
Dressed Self	
Toilet Trained	

SPEECH AND LANGUAGE HISTORY

Please report what age your child did the following:

Babble (Dada, Mama, Goo-goo)	
Jargon (Sounds like a garbled sentence)	
Said First Words (Even if not clear)	
Combined Words (Daddy shoe)	

CURRENT COMMUNICATION BEHAVIOR

RESPONDS TO ENVIRONMENTAL SOUNDS (Dog barks, Doorbell)? Yes: ____ No: ____

FOLLOWS INSTRUCTIONS WITH GESTURES? Yes: ____ No: ____

FOLLOWS INSTRUCTIONS WITHOUT GESTURES? (Ex. Go get your ball) Yes: ____ No: ____

CAN FOLLOW 2-STEP COMMANDS? (Ex. Go in your room and bring me your PJ's) Yes: ____ No: ____

HOW DOES YOUR CHILD LET YOU KNOW WHAT HE WANTS? Cries: ☐ Points: ☐ Uses Words: ☐ Uses Phrases: ☐

DOES YOUR CHILD APPEAR TO UNDERSTAND WHAT YOU TELL HIM/HER? Yes: ____ No: ____

IS YOUR CHILD EASILY UNDERSTOOD BY FAMILY MEMBERS? Yes: ____ No: ____

DO THOSE OUTSIDE THE FAMILY UNDERSTAND YOUR CHILD? Yes: ____ No: ____

WHEN NOT UNDERSTOOD, WHAT DOES YOUR CHILD DO? _____

DOES YOUR CHILD APPEAR FRUSTRATED IF NOT UNDERSTOOD? Yes: ____ No: ____

HAS YOUR CHILD'S SPEECH CHANGED IN THE LAST 6 MONTHS? Yes: ____ No: ____

If yes, please describe: _____

DOES YOUR CHILD EVER SOUND HOARSE? (Please circle) All the Time / Sometimes / Never

DOES YOUR CHILD SCREAM / MAKE LOUD NOISES WITH HIS/HER VOICE? Yes: ____ No: ____

Please describe: _____

DOES YOUR CHILD REPEAT WHOLE WORDS and/or PARTS OF WORDS WHEN TALKING? Yes: ____ No: ____

Please describe: _____

APPROXIMATELY, HOW MANY WORDS DOES YOUR CHILD USE SPONTANIOUSLY? _____

PLAY BEHAVIOR

WHAT ARE YOUR CHILD'S FAVORITE TOYS & ACTIVITIES? _____

_____

DOES HE/SHE PLAY BY HIM/HERSELF? Yes: ____ No: ____

DOES HE/SHE PLAY WELL WITH OTHER CHILDREN? Yes: ____ No: ____

DOES HE/SHE PREFER TO PLAY ALONE OR WITH OTHER CHILDREN? _____ (Younger / Same age / Older?)

WHAT OPPORTUNITIES DOES YOUR CHILD HAVE TO INTERACT WITH CHILDREN OF THE SAME AGE? _____

_____

SCHOOL HISTORY

Please list all schools your child has attended:

Date	School	Address	Teacher

DOES YOUR CHILD HAVE A CURRENT **IEP** or **IFSP** AND IF SO, WHAT SERVICES ARE BEING PROVIDED? _____

_____

HOW OFTEN? _____

DISCIPLINE

WHO DOES THE MOST DISCIPLINING AND HOW? _____

_____

WHAT BEHAVIORS REQUIRE THE MOST DISCIPLINE? _____

Please circle the words that best describe your child.

Active	Alert	Crabby	Cuddly	Cute	Demanding	Difficult	
Easy	Fidgety	Floppy	Fussy	Giggly	Grouchy	Has a temper	Hungry
Jumpy	Lazy	Loveable	Mean	Nasty	Nervous	Passive	Quiet
Serious	Shy	Sickly	Slow	Smart	Smiley	Spoiled	Squirmy
Stiff	Strong	Stubborn	Sweet	Talkative	Tense	Touchy	Whiney

DESCRIBE SOME OF YOUR CHILD'S TALENTS AND ABILITIES: _____

_____

_____

_____

Thank you for choosing HEAR Center for your child's speech and language needs.

Did you know that HEAR Center is a 501(c)(3) non-profit agency? **We provide free hearing and speech screenings for children and seniors** in our community schools and centers every week. You can help us continue this important public service by donating just $5, $10, or $20. See the front desk for details!

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Payment is due at time of service. How are you paying for services today?
□Cash □Check □Visa/MC □CCS □Medi-Cal □Medicare □Regional Center □HMO □PPO

Patients name _____ Date of Birth_____

Child Lives with: □Mother □Father □Both Parents □Other, _____

Mother's Name (or Legal Guardian)_____
Address (If different from patient's) _____
Email _____
Occupation _____ Work # _____Alternate # _____

Father's Name (or Legal Guardian)_____
Address (If different from patient's) _____
Email _____
Occupation _____ Work # _____Alternate # _____

Emergency Contact Name _____Relationship _____
Address _____ City _____ State_____ Zip_____
Phone _____

Please answer the following questions to the best of your knowledge.

Have you observed a hearing loss? □No □Yes, explain _____

Does child respond to soft sounds? □No □Yes **If No**, explain_____

Did child have a Newborn Hearing Screening when born? □No □ Yes **Passed screening** □Yes **Failed Screening**

Ear Surgery? □No □Yes, explain _____

Meningitis? □No □Yes, explain _____

Head Injuries? □No □Yes, explain _____

Ototoxic Drugs (drugs that may cause hearing problems)? □No □Yes, explain _____

Seizures? □No □Yes, explain_____

Medical Condition(s)/Syndromes? □No □Yes, explain _____

Did mother have German measles during pregnancy? □No □Yes When? _____

Premature birth? □No □ Yes How many weeks early? _____ Complications: _____

Anoxia (not enough oxygen during birth)? □No □Yes, explain _____

Wears hearing aids? □No □Yes At what age? _____Where fitted with aids? _____

Family history of hearing loss **(before age 40)?** □No □Yes Relationship _____

Answer the following questions if your child is 10 years or younger

Age child sat up _____ Age walked _____

Is child's coordination good?	□No	□Yes
Is child's vision good?	□No	□Yes
Is child's language normal for age?	□No	□Yes
Does child babble?	□No	□Yes
Does child gesture instead of voice?	□No	□Yes
Does child understand speech?	□No	□Yes
Does child have unclear speech?	□No	□Yes

Release of information (to physician, school, and other agencies working with child)

I hereby authorize HEAR Center to release information. The authority extends to the furnishing of copies of all desired parts of these records. The question of privacy between the HEAR Center, the attending physician(s) and patient is waived.

Signature: _____ Date: _____

Information on this form is confidential and released ONLY with your consent.

Thank you for choosing HEAR Center for your child's hearing and speech and language needs.

Did you know that HEAR Center is a 501(c)(3) non-profit agency? **We provide free hearing and speech screenings for children and seniors** in our community every week. You can help us continue this important public service by donating just $5, $10, or $20. See the front desk for details!

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PATIENT INFORMATION

{Please Print}

Last Name:_____ First Name:_____

Address:_____ Apt.#:_____

City:_____ State:_____ Zip Code:_____

Home phone#: ( )_____ Work phone#: ( )_____

Cell Phone #: ( )_____ E-Mail _____

Date of Birth:_____ Age:_____ Sex:_____

Social Security#:_____ Driver's License#:_____

Ethnicity: ☐ Asian ☐ Black/African Amer. ☐ Amer. Indian/Alaska Native ☐ Latin/Hispanic
☐ Pacific Islander ☐ White/Caucasian ☐ Other

How Did You Hear About Us? Please indicate from choices below.

☐ Pasadena Star Newspaper ☐ Pasadena Senior Center Magazine ☐ YELP ☐ Online Search
☐ Senior Center _____ ☐ Friend _____ ☐ Client _____ ☐ Other _____

What is the name of the Physician that referred you HEAR Center?_____

RESPONSIBLE PARTY

Last Name:_____ First Name:_____

Relationship to patient:_____

Address:_____ Apt.#:_____

City:_____ State:_____ Zip Code:_____

Home phone#: ( )_____ Work phone#:( )_____

E-Mail home:_____ E-Mail Work:_____

Date of Birth:_____ Age:_____ Sex:_____

Social Security#:_____ Driver's License#:_____

INSURANCE INFORMATION

Insured Name:_____ Date of Birth:_____

Insurance company name:_____ Subscriber:_____

Complete Insurance Address:_____

Policy/Group#:_____ Employer:_____

Check one: ☐ HMO ☐ PPO ☐ Medicare ☐ Medi-cal ☐ other_____

SECONDARY INSURANCE (MEDICARE PATIENTS ONLY)

Check one: ☐ Supplemental or ☐ Retirement Plan

Insured Name:_____ Date of Birth:_____

Insurance company name:_____ Subscriber:_____

Complete Insurance Address:_____

Policy/Group#:_____ Employer:_____

Check one: ☐ HMO ☐ PPO ☐ Medicare ☐ Medi-cal ☐ other_____

I hereby assign to HEAR Center all monies to which I am entitled for charges(s) related to the service(s) provided. I understand that I am financially responsible to HEAR Center for charges not covered by this assignment. Also, I authorize the release of any information in order to process claims.

Signature:_____ Date:_____

Who do you authorize to receive copies of records?
Please complete one section for each physician, facility, or for yourself.

I, the undersigned, hereby authorize HEAR Center to provide medical information or records to:

Person or Physician:______________________________ Phone:______________

Address:____ Apt.#__________

City:__________________________ State:__________ Zip code:____________

Signature of representative to patient:______________________________________

I, the undersigned, hereby authorize HEAR Center to provide medical information or records to:

Person or Physician:______________________________ Phone:______________

Address:____ Apt.#__________

City:__________________________ State:__________ Zip code:____________

Signature of representative to patient:______________________________________

I, the undersigned, hereby authorize HEAR Center to provide medical information or records to:

Person or Physician:______________________________ Phone:______________

Address:____ Apt.#__________

City:__________________________ State:__________ Zip code:____________

Signature of representative to patient:______________________________________

I, the undersigned, hereby authorize HEAR Center to provide medical information or records to:

Person or Physician:______________________________ Phone:______________

Address:____ Apt.#__________

City:__________________________ State:__________ Zip code:____________

Signature of representative to patient:______________________________________

CONSENT TO RELEASE MEDICAL HISTORY

_____ _____

Patient Name: Date of Birth:

_____ _____

City: State:

_____

Date:

To Whom it May Concern:

This authorizes all physicians, hospitals, and medical attendants to furnish any and all medical records, history and information to HEAR Center, or to any representative of HEAR Center, concerning my medical condition. This authorization also includes examination of all hospital records, x-ray film, and furnishing of any information including opinions. You are further requested not to disclose such information to any other person without written authority to do so.

_____

Patient / Parent / Legal Guardian

FINANCIAL POLICY
STATEMENT OF FINANCIAL RESPONSIBILITY

Thank you for using HEAR Center as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. All patients must read and sign this policy before being seen.

ALL COPAY AND DEDUCTIBLE MONIES ARE DUE AT TIME OF SERVICE
WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD AND AMERICAN EXPRESS

REGARDING INSURANCE

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. All charges incurred are the responsibility of the patient or their guarantor. We will bill your insurance company as a courtesy. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. If your insurance company has not paid your account within 60 days the balance will automatically be billed to you. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Benefit inquiries and authorizations are not a guarantee of payment by your insurance company.

OVERPAYMENT

Our policy is to collect a payment of 50% of charges at the time of service for non provider insured patients, unless other arrangements have been made. If you feel you have overpaid please feel free to contact our billing department so we can research and process any refunds due to you. All refunds are processed in the same manner as payment was received. If any credits on your account are due to insurance overpayments a refund will be made to the insurance company.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Prearranged contract rates will be honored.

MINOR PATIENTS

The adults accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, MasterCard or American Express, or payment by cash or check at time service has been provided.

MISSED APPOINTMENTS

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments fee of $40 for Speech Therapy and $25 for Audiological Evaluations. Please help us serve you better by keeping scheduled appointments.

INTEREST

We reserve the right to charge interest in the amount of 10% as provided by state law.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy:

_____
Name Printed

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Signature of Co-Responsible Party Date

Speech Therapy Attendance Policies

Client Name: _____

Attendance must be regular and punctual; it is an **essential** component of your treatment plan and your child's progress.

All clients must adhere to the following:

Appointments:

A. Always be prompt. If you are 10 minutes late or more to your scheduled appointment, the therapy session may be cancelled and will be considered a No Show. Parents may observe your dependent's therapy session from the **Observation Room**. Please inform your therapist of your request to observe your dependent's therapy session. Please adhere to the posted Observation Room Policies.
B. Cash/PPO clients: Please note that thirty (30) minute sessions consist of twenty five (25) minutes of treatment and five (5) minutes of documentation. Sixty (60) minute sessions consist of fifty (50) minutes of treatment and ten (10) minutes of documentation.
C. Please note that HCP/HMO clients have forty-five (45) minute sessions.
D. Clients are responsible for monitoring their attendance.

No Show to Appointment:

A. Clients will be billed **$40** for all NO-SHOW Appointments or if cancelation of appointment is made less than 1 hour before the scheduled appointment time.
B. If 2 or more NO-SHOWs occur within a year, the client may be immediately discharged from the therapy schedule at HEAR Center.

Cancellation of Appointment:

A. **Cancelled appointment rules:**
    1. One (1) cancelled appointment per month.
    2. 2nd Cancellation or more in one month, must fulfil one of the 2 options:
        a. Pay $40 Fee, or
        b. Make-up each cancelled appointment within 14 days of missed date (no extension will be given for make-up appointments).If a make-up session is not completed within 14 days, $40 fee will be charged.

    HEAR Center staff will not keep track of missed appointments or remind you to schedule make-up. Parents are expected to keep track of their child's schedule and to schedule any make-ups for any missed appointments. Make-up appointments are limited spots and will be given on a first called first served basis. If by the time you call there are no available make-up appointments, we will not be responsible for making up the session and there will be a fee of $40.
B. **If you must cancel your appointment, please notify the scheduling department at (626) 796-2016 1 hour prior to the appointment, otherwise the cancellation will be considered a No Show. You may leave a message 24 hours/day.**
C. Make up session(s) may be available based on your adherence to our attendance policy.
D. Services may be terminated or the client returned to the waiting list if the following occur:
    1. Client has 6 no shows/cancels at any point in a calendar year.
    2. Client maintains an open balance in fees of $80 or more.
E. In the event that the client will be on vacation or requests extended leave time due to illness, HEAR Center will make every effort to hold the appointment time slot for 2 weeks.

This policy will be strictly enforced.

Parents / Caregivers of minor children:

A. An adult must accompany a child to the Center and be available for the duration of the appointment. **If the adult leaves the premises, excess lateness in picking up the child will result in a late pick up fee and or termination from future therapy sessions**.
B. In the event that the parent and or caregiver does not pick up their child after five (5) minutes from the end of the scheduled appointment, then at the discretion of the employees of HEAR Center we may file an abandonment report with the local police department.

Immediate Termination of Services:

A. **HEAR Center reserves the right to terminate services at any time.**

* Please take all concerns directly to the treating clinician. If you are unable to resolve the issue, you may then make an appointment to speak to the Executive Director.

I have read, understand and have received a copy of the attendance policy mentioned above governing therapy at HEAR Center. My signature below also gives permission for the client and professionals in training to observe my sessions.

_____ _____ _____

SIGNATURE NAME DATE

NOTICE OF PRIVACY PRACTICES
Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices*** of

HEAR CENTER

Our ***Notice of Privacy Practices*** provides information about how we may use and disclose your protected health information. We encourage you to read in full.

Our ***Notice of Privacy Practices*** is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting HEAR Center at (626)796-2016.

I acknowledge receipt of the ***Notice of Privacy Practices*** of **HEAR Center**

Signature: _____ Date: _____
Parent/patient/conservator/guardian

Print patient Name: _____

FOR OFFICE USE ONLY

INABILITY TO OBTAIN AKCNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement and the reason why the acknowledgment was not obtained.

Signature of provider representative: _____ Date: _____

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other (Please Specify) _____