

UNIVERSITY OF WASHINGTON
SPEECH and HEARING CLINIC
4131 15th Avenue NE Seattle WA 98105-6246
Phone 206-543-5440 Fax # 206-616-1185
http://depts.washington.edu/sphsc

<i>Clinic Use Only</i>
Date application received: _____
File # Assigned: _____
Entered into DB: _____
C:revised 6/02

APPLICATION FOR AUDIOLOGY SERVICES – CHILD

Please answer all items on this questionnaire the best you can. We are interested in learning about your child's hearing problem from you. This information is confidential and will not be released without your permission. Wherever space is not sufficient, continue your answer on the back of the page. Mail your application back to us as soon as possible.

Today's date: _____ Child's name: _____ Birth date: _____ Male Female

Parent/Legal Guardian name _____

Yes No Lives with child? Relationship: _____

Child's Address: _____

(City, State, Zip) _____

Parent/Legal Guardian Address: _____

(City, State, Zip) _____

Telephone numbers for parent/legal guardian:

Home: (____) _____ - _____ Voice / TTY Who answers? _____

Work: (____) _____ - _____ Voice / TTY Who answers: _____

Fax: (____) _____ - _____ Home / Work

E-mail address: _____

Yes No Has child been to our clinic before?

When? _____

Who referred you to us? _____

INSURANCE INFORMATION:

The Speech and Hearing Clinic Does Not Bill Insurance Companies. When services are paid in full by cash or check, the clinic will issue an Itemized Insurance Statement for you to submit to your Insurance Carrier for reimbursement to you. We **DO** accept Medical Coupons* from the State of Washington for payment.

*Medicaid Coupons (DSHS) YES: _____ NO: _____

(*We must have a current copy on file of a DSHS coupon per month for services rendered)

Other Insurance: _____

Address where reports and/or bills should be sent (if different from above address)

Bill to: _____

Street Address _____

(City, State, Zip) _____

What would you like us to provide? Check all that apply.

Hearing Evaluation (test child's hearing and inform you of the findings)

Hearing Aid Evaluation (discuss different kinds of hearing aids and determine if child would benefit)

Audiologic Rehabilitation (teach child speech-reading, listening and communication strategies)

Personal Background:

Yes No Does child attend school/preschool?

Where? _____

Yes No Is child in special classes?

Describe? _____

What does your child enjoy doing?

What other persons live with child? (List name and relationship of parent, brother/sister, friend, other)

General Medical Information

How is child's general health? _____

Major medical problems: _____

Surgeries: _____

Yes No Ear infections. How many? _____ Describe. _____

Yes No Tubes placed in ears? When? _____ Describe _____

If child is taking any medications regularly, please write the medication and reason for taking it:

Medication	Reason
_____	_____
_____	_____
_____	_____

Yes No Was child's birth normal? If no, describe. _____

Yes No Does child have physical handicaps? If so, describe _____

Hearing Loss History:

What makes you concerned about child's hearing? _____

Do you think child's hearing changes? _____

When was child's last hearing evaluation _____

Where was this evaluation done _____

Right ear Left ear Which is child's better ear?

At what age did child's hearing loss begin? _____

How long has child had a hearing loss? _____

What is the cause of child's hearing loss: _____

Yes No Do child's blood relatives have a significant hearing loss? Give the relationship (mother, aunt, etc.) and a bit about their hearing loss.

Add anything else you think might be important for us to know about child's hearing loss.

Hearing Aid History:

When did child receive first hearing aids? Right ear _____ Left ear _____

Yes No Is child using hearing aids now?

Right ear Make and Model _____ Dispenser _____ Year purchased _____

Left ear Make and Model _____ Dispenser _____ Year purchased _____

Yes No Are you satisfied with the help your child's hearing aids provide? If not, explain.

 Yes No Does your child like to wear the hearing aids? If not, explain:

If child is not wearing hearing aids now, how long has it been since they were worn? _____

Assistive Listening Devices History:

Yes No Is child using any special devices to help with hearing? (FM, alerting devices, etc.)

If yes, describe them _____

Yes No Is child using any special devices with the telephone? (amplified phone, cushions, etc.)

If yes, describe them. _____

Communication History:

Yes No Do you have concerns about child's speech/language?

Describe _____

Yes No Child has had speech/language evaluated? Where _____

Results _____

Yes No Has your child taken classes in learning to communicate better?

Describe child's most difficult communication problems.

NOTE: When visiting the clinic:

Please bring a copy of any hearing test results and any hearing aids child has to the first appointment.

**Speech and Hearing Clinic
University of Washington
4131 – 15TH Avenue NE
Seattle, WA 98105**

Instructions: Please read this consent form carefully. If you are comfortable with the contents therein, please sign this form and return it with your application materials. If you have any questions or concerns about this form, please return the application without it. Then bring this form (unsigned) to the first appointment.

Consent Form

This Service Agreement and Consent (“Agreement”) is between you and the University of Washington Speech and Hearing Clinic (“the Clinic”). This Agreement concerns: (1) your financial obligations; and (2) your consent to have recordings made of the person receiving services (the “client”) and/or the person authorizing services (the “authorizing individual”).

1. Your Financial Obligations

You are responsible for the fees for service stated on the attached face sheet. The Clinic does not directly bill insurance companies or Medicare/Medicaid. You are responsible for payment of all fees to the Clinic regardless of any such coverage. The Clinic will furnish you an itemization of services received and paid for in cases where insurance companies will reimburse for services.

The exception to the above is if you have valid medical coupons issued by the Department of Social and Health Services (DSHS). In that case, you must show a current medical coupon to verify eligibility and your clinic fees will then be waived.

Fees are subject to change without notice

2. Your Consent for Services and Recording

The services offered to individuals seen in the Clinic and its affiliated laboratories are part of the University’s education program. University of Washington faculty, staff, and students receive educational benefits from observing diagnostic, treatment, and other services offered in the University of Washington facilities.

2a. Minimum Consent:

By accepting services from the Clinic and its affiliated laboratories, you consent to observation by University of Washington faculty, staff, and students, either live, via recording or via closed circuit television when you (or the client) receive services.

2b. Additional Consent:

In addition, the University of Washington may make audio and/or video recordings of you (or the client) during such service periods to be used for the University’s educational, research or technology transfer purposes provided the name of the client or other personal identification information is not revealed. The University may use, distribute, reproduce, and display these recordings, in whole or in part and in any media now known or later developed (including the World Wide Web, television and/or CD-Rom) or may permit others to do so. Such uses may include, but are not limited to, the following:

- Viewing/listening by registered students or participants in activities conducted, sponsored or licensed by University of Washington faculty or staff.
- Viewing/listening by the general public at activities or through media sponsored or licensed by the University of Washington or its faculty or staff. (e.g. Internet/World Wide Web, University of Washington TV)
- Viewing/listening by the general public through licensed commercial enterprises for educational or research purposes, for example a CD-Rom enclosed in a textbook.

Again, if you have any questions or concerns about these uses of recordings, please bring this form (unsigned) to the first appointment to discuss alternatives.

Name of client

Date

Signature of Authorizing Individual

Relationship of Authorizing Individual to the Client:

- Self
- Parent
- Legal guardian
- Other. Please explain relationship: _____

Printed Name of Authorizing Individual: _____

Address of Authorizing Individual: _____

Phone Number of Authorizing Individual: _____

=====
For Office Use Only:

Date Received: _____

Received by: _____

**UNIVERSITY OF WASHINGTON
SPEECH AND HEARING CLINIC**

4131 15th Avenue, NE
Seattle, WA 98105
Telephone: (206) 543-5440
Fax: (206) 616-1185

**AUDIOLOGY: MUTUAL EXCHANGE OF
INFORMATION**

Please list the professionals who have provided your most recent health care.

This release is good for ninety (90) days from the date below and must be renewed for use beyond that time. By signing this release, I understand that I will be notified of any other requests for information that are received by this office, in order to give my permission to release information on the named individual. I understand this information will be shared for professional use only and confidentiality will be maintained. I may revoke this release in writing at any time.

Agreement for Mutual

Audiologist:

Name _____
Facility _____
Address _____

Phone _____

Hearing Aid Dispenser (if different from Audiologist):

Name _____
Facility _____
Address _____

Phone _____

Physician Ear Specialist (Otologist) or Primary Health Care

Physician:

Name _____
Facility _____
Address _____

Phone _____

Exchange of Information

I hereby give my permission for the mutual exchange of information between this professional and the University of Washington Speech & Hearing Clinic regarding the records of:

Name _____
Date of Birth _____
Signature _____
Signature Date _____

I hereby give my permission for the mutual exchange of information between this professional and the University of Washington Speech & Hearing Clinic regarding the records of:

Name _____
Date of Birth _____
Signature _____
Signature Date _____

I hereby give my permission for the mutual exchange of information between this professional and the University of Washington Speech & Hearing Clinic regarding the records of:

Name _____
Date of Birth _____
Signature _____
Signature Date _____