Date

clarity

PATIENT INFORMATION FORM

PATIENT INFORMATION

Patient's Last Name | Patient's First Name | Patient's Middle Name | Suffix | Preferred name

Date of Birth ☐ Male ☐ Female Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Another ______

Race: ☐ Caucasian (White) ☐ American Indian ☐ African American (Black) ☐Hispanic ☐ Asian ☐ Multiracial ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Refused/Declined Primary Language: ____________

Home address: ____________ City: ____________ State: ________ Zip: ________

Mail to address: ____________ City: ____________ State: ________ Zip: ________
(If different from home address)

Home Phone: ( ) ____________ ☐ This is the primary number for patient. Cellphone: ( ) ____________ ☐ This is the primary number for patient.

Primary Email Address: ____________

EMERGENCY CONTACT (Pediatric Patients, please list someone other than parents/guardians)

Name: ____________ Home Phone: ( ) ____________ Relation to Patient: ____________

PARENT/GUARDIAN INFORMATION (Pediatric patients only)

Parent/Guardian 1 (If the address and/or phone numbers are the same as patient, please indicate same.)

Name: Last | First | Middle | Nickname

Date of birth: ____________ (Month/Day/Year) Home Phone: ( ) ____________ Cell Phone: ( ) ____________

Home address: ____________ City: ____________ State: ________ Zip: ________
(If different from the patient)

Employer: ____________ Work Phone: ( ) ____________ Ext.

Parent/Guardian 2 (If the address and/or phone numbers are the same as patient, please indicate same.)

Name: Last | First | Middle | Nickname

Date of birth: ____________ (Month/Day/Year) Home Phone: ( ) ____________ Cell Phone: ( ) ____________

Home address: ____________ City: ____________ State: ________ Zip: ________
(If different from the patient)

Employer: ____________ Work Phone: ( ) ____________ Ext.

RESPONSIBLE PARTY

The Responsible Party is the person who is financially responsible for the patient's account and who will receive all account statements to their address.

Last Name | First Name | Middle Name | Relation to Patient

Home Phone: ( ) ____________ (If different from the patient) Cell Phone: ( ) ____________ (If different from the patient)

Mail to address: ____________ City: ____________ State: ________ Zip: ________
(If different from the patient)

Social Security Number:

THIS IS A TWO PAGE FORM

Clarity, Inc. | 29 North Academy Street | Greenville, SC 29601 | PH: 864-331-1400 | FAX: 864-331-1416

Patient Name: ______________ ______________ ______________ Date of Birth: ______________
Last First Middle Month/Day/Year

☐ **Check here if no insurance. Skip to authorizations (below).**

PRIMARY INSURANCE INFORMATON (Please present insurance card and ID to Business Office)

Subscriber: This is the person who carries the insurance. If the subscriber is the patient, skip to insurance co. name field.

Subscriber's name on card: ______________ Subscriber's date of birth: ______________
Month/Day/Year

Patient relationship to subscriber: ______________

If address and phone number is same as patient, please indicate same.

Address: ______________ City, State, ZIP: ______________ Home Phone: ( )

Insurance co. name: ______________ Phone: ______________

Policy/Cert #: Group no.: Effective Date:

SECONDARY INSURANCE INFORMATON (Please present insurance card and ID to Business Office)

Subscriber: This is the person who carries the insurance. If the subscriber is the patient, skip to insurance co. name field.

Subscriber's name on card: ______________ Subscriber's date of birth: ______________
Month/Day/Year

Patient relationship to subscriber: ______________

If address and phone number is same as patient, please indicate same.

Address: ______________ City, State, ZIP: ______________ Home Phone: ( )

Insurance co. name: ______________ Phone: ______________

Policy/Cert #: Group no.: Effective Date:

AUTHORIZATIONS

I authorize evaluation and treatment and I authorize release of information for insurance/medical purposes concerning evaluation and/or treatment serivces provided to me by Clarity, Inc. I hereby also authorize payment from my insurance company to Clarity, Inc. for services rendered. In addition, I authorize audio recording for the purpose of accurate scoring during the provision of evaluation services.

Signature ______________ Relation to Patient ______________ Date ______________

ACCEPTANCE OF PAYMENT POLICIES AND FINANCIAL RESPONSIBILITY

I understand that some services provided by Clarity, Inc. may not be covered by my insurance and that I will be responsible for any amount not covered by my insurance at the time of service. I understand that it is my responsibility to notify Clarity, Inc. if my insuranve coverage changes and that I will be financially responsible for any noncovered services. I understand that Clarity, Inc. will collect all applicable copays, deductibles, coinsurance, and fees for services not covered by my insurance at the time services are rendered.

If a deposit is required for scheduled services I understand that if I cancel the appointment(s) within (2) weeks of the appointment(s) and choose not to reschedule the appointment(s), the deposit will be forfeited. This policy does not apply to appointments that must be rescheduled due to illness or family emergency. I further acknowledge that only one reschedule will be allowed before my deposit is forfeited (this does not apply if Clarity, Inc. has to reschedule the appointment).

Signature ______________ Relation to Patient ______________ Date ______________

LATE CANCELLATION AND NO-SHOW POLICY

*I understand that if for any reason I am unable to keep a scheduled appointment, I must contact Clarity at least 24 hours in advance at **(864) 331-1400** to cancel or reschedule. If **two** appointments (in any six-month period) are missed or cancelled with less than 24 hours' notice, Clarity will reschedule the appointment **after** a six-month waiting period from the time of the missed appointment.*

Signature ______________ Relation to Patient ______________ Date ______________

Clarity, Inc. | 29 North Academy Street | Greenville, SC 29601 | PH: 864-331-1400 | FAX: 864-331-1416

Privacy Practices and Authorization for Disclosure of Medical Information

The privacy of your medical information is important. We will only share information about the services you receive at Clarity, Inc. with person(s) you designate and via the mean(s) you specify. This authorization shall be in enforce for six years, until the patient reaches the age of majority (18 years of age) or until this authorization is revoked by the patient or the patient's personal representative.

Patient Name: ______________ ______________ ______________ Date of Birth: ______________
Last First Middle Month/Day/Year

PATIENT'S VERIFICATION CODE

Clarity, Inc. will verify the identity of a person requesting protected health information. Please provide a word/phrase that Clarity, Inc. can ask for to verify identity: ______________________________

SHARING INFORMATION WITH OTHERS

Please CHECK the information below that you authorize Clarity, Inc. to give out for the above patient, and list who has permission to receive this information other than the patient's parents/legal guardians.

☐ Results of Evaluations ☐ Appointment Information ☐ Billing Information ☐ Treatment Information

Name of person that has permission to receive the above patient information | Relationship to Patient

Name of person that has permission to receive the above patient information | Relationship to Patient

COMMUNICATION BY PHONE

I authorize Clarity, Inc. to leave a voice message on the phone number below regarding: Check ONLY ONE

☐ All Information including appointments, general information, updates, billing etc.
☐ Appointment information ONLY

( )
Phone Number | Relationship to Patient

COMMUNICATION BY EMAIL

Please be aware that email communications can be intercepted during transmission or misdirected. Your use of and authorization for the use of email to communicate Protected Health Information or other information of a confidential nature with Clarity, Inc. indicates that you acknowledge and accept the possible risks associated with such communication. **Please CHECK the information below that you authorize Clarity, Inc. to release about above patient via email and the email address(es) you authorize Clarity, Inc. to send Protected Health Information.**

☐ Results of Evaluations ☐ Appointment Information ☐ Billing Information ☐ Treatment Information

Email Address | Name of the account owner for this email address | Relationship to Patient

Email Address | Name of the account owner for this email address | Relationship to Patient

RIGHTS OF THE PATIENT

I understand that I have the right to refuse to sign this Authorization and that my treatment will not be conditioned on signing. I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. Information received by this office is for our own use and will continue to be protected by our Privacy Policy. I understand that I have the right to inspect or obtain a copy of the protected health information disclosed as described in this document. I can do this by written notification to the address below.

I authorize disclosure of the information listed above by the means specified and I have read and received a copy of the Notice of Privacy Practices for Clarity, Inc.

Signature | Relation to Patient | Date

Clarity, Inc. | 29 North Academy Street | Greenville, SC 29601 | PH: 864-331-1400 | FAX: 864-331-1416

HIPAA Notice of Privacy Practices

Effective as of April 14, 2003
Revised November 16, 2018
Contact: (864) 331-1400

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

This Notice of Privacy Practices is not an authorization. The Notice of Privacy Practices describes, how we our Business Associates and their subcontractors, may use and disclose protected health information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" (also referred to as PHI) is health information is information about you, including demographic information, that may identify you and that relates to your past present, or future physical or mental health care condition and related health care needs.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operation of Clarity, Inc., and any other use required by law.

Treatment- We may use or disclose your protected health information in consultation between health care providers relating to your treatment or for your referral to another health care provider for your treatment.

Payment- We may use or disclose your protected health information for billing, claims management, collection activities, or obtaining payment.

Health Care Operations- We may use or disclose your protected health information for reviewing the competence or qualifications of health care professionals, or for conducting training programs in which students, trainees, or practitioners participate. We may use or disclose your protected health information for accreditation, certification, licensing, or credentialing activities. We may use or disclosure your protected health information to our business associates who participate in our healthcare operations. These disclosures will only be made after we have satisfactory assurances in the form of a Business Associates Agreement from the business associate. These assurances will include their agreement to comply with the HIPAA rules and the compliance of any subcontractor with which they do business. We may use or disclose protected health information to remind you of your appointment, to give you information about treatment alternatives, or other health related benefits or services. If you do not wish to receive appointment reminders or the information about treatment alternatives, other health related benefits, services, you may notify our office and you will receive no further information.

Fundraising- We may contact you for our **own** fundraising activities**.** If you do not want to receive fundraising communication, you may opt-out at any time. Each communication will contain methods to be used to opt-out of further communication. If you opt-out, you will receive no further fundraising communications. If at any time you wish to receive fundraising communication you wish to receive the communication again, you can contact our practice.

USES AND DISCLOSURE THAT REQUIRE YOUR AUTHORIZATION

The following uses or disclosures require a **valid** authorization as defined by the HIPAA standards.

Uses or Disclosures for Psychotherapy Notes- We will require written authorization for most uses and disclosures of psychotherapy notes, where applicable.

Uses or Disclosures for Marketing Purposes- We will require an authorization for uses and disclosures of protected health information used in marketing.

Disclosures for a Sale of Protected Health Information- We will require an authorization for any disclosures that would constitute a sale of protected health information**.**

For any other use or disclosure, you wish us to make, you can give us a written, valid authorization. Your authorization must have specific instructions for the use and disclosure you want us to make. You will have the right to revoke the authorization in writing at any time before the information is used or disclosed.

USES OR DISCLOSURES REQUIRING AN OPPORTUNITY FOR THE INDIVIDUAL TO AGREE OR OBJECT

For disclosures to others involved with your health care or payment, we will inform you in advance and give you the opportunity to agree or object. These disclosures will be limited to the information necessary to help with your health care or payment. These disclosures will only be made if you do not object.

USES AND DISCLOSURES FOR WHICH AN AUTHORIZATION OR OPPORTUNITY TO AGREE OR OBJECT IS NOT REQUIRED

The following uses or disclosures do not require an authorization or the opportunity for you to agree or object.

Uses and disclosures required by law- We may use or disclose protected health information to the extent required by law. The use or disclosure will comply with and be limited to the relevant requirements of such law.

Uses and disclosures for public health activities- We may use or disclose protected health information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, and vital events such as birth or death.

Disclosures about victims of abuse, neglect or domestic violence- We may disclose protected health information about an individual whom We reasonably believes to be a victim of abuse, neglect, or domestic violence.

Uses and disclosures for health oversight activities- We may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations, inspections, licensure, or disciplinary actions.
Disclosures for judicial and administrative proceedings- We may, in response to an order of a court or administrative tribunal, provide only the protected health information expressly authorized by such order or a subpoena.
Disclosures for law enforcement purposes- We may disclose protected health information as required by law including laws that require the reporting of certain types of wounds or other physical injuries.
Uses and disclosures about decedents- We may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may disclose protected health information to a funeral director, as authorized by law, to carry out their duties. This disclosure will be made in reasonable anticipation of death.
Uses and disclosures for cadaveric organ, eye or tissue donation purposes- We may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.
Uses and disclosures for research purposes- We may use or disclose protected health information for research, when the research has been approved by an institutional review board or privacy board, to protect your protected health information.
Uses and disclosures to avert a serious threat to health or safety- We may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, in good faith, if we believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
Uses and disclosures for specialized government- We may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, if the appropriate military authority has published by notice in the Federal Register.
Disclosures for workers' compensation- We may disclose protected health information as authorized by and to the extent necessary, to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

PATIENT RIGHTS UNDER HIPAA

The following information describes your rights under the HIPAA Standards. We require that all requests for the various rights be made in writing and we will provide our decision on your request in writing. You should be aware that there may be some situations when there could be limitations placed on your rights. We are required to permit you to request these rights, but we are not required to agree to your request, **except as in the Right of Restriction section.**
Right of an individual to request a restriction of uses and disclosures- We will permit an individual to request that we restrict uses or disclosures of protected health information about the individual to carry out treatment, payment, or health care operations or to others involved in your care or in payment. We will consider these requests, but we are not required to agree to them, except as discussed in the next section. Under your right of restriction, you may restrict certain disclosures of protected health information to a health plan for payment or healthcare operation, where payment in full is made out of pocket for a healthcare item or service. We will agree to this restriction as long as your payment is honored. If payment is not honored, we are not obligated to continue to abide by the requested restriction.
Confidential communication requirements- We will permit an individual to request and will accommodate reasonable requests to receive communications of protected health information from our practice by alternative means or at an alternative location.
Access of individuals to protected health information- An individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set except as prohibited by state or federal law or certain other exemption. Your access may be provided in electronic form if producible at your request or in another form or format. As permitted by state and federal law, we may charge you a reasonable cost-based fee for a copy of your record. Questions about the fee should be addressed to our Privacy Officer at the phone number listed at the end of this document.
Amendment of protected health information- An individual has the right to ask to have We amend protected health information or a record about the individual in a designated record set for as long as the protected health information is maintained in the designated record set.
Accounting of disclosures of protected health information- An individual has a right to receive an accounting of disclosures of protected health information made by us in the past six years but not before April 14, 2003. The accounting will not include disclosures made for treatment, payment, or operations, as well as authorized disclosures or disclosures made for which you had an opportunity to agree or object. You may receive one free accounting in a 12-month period. There will a reasonable cost-based fee for additional requests.
Right of Breach Notification- An individual has the right to and will receive a notification of any breach of their unsecured protected health information as defined by the Breach Notification Rule. We will fulfill our obligation to provide notice in accordance to HIPAA standards.

COPY OF THIS NOTICE

You have a right to a copy of this notice. Even if you agreed to receive an electronic copy, you may request and receive a paper copy.

OUR DUTIES

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.
We are required to abide by the terms of the notice currently in effect.
We are required to notify you of any change in a privacy practice that is described in the notice to protected health information that we created or received prior to issuing a revised notice. We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. Revised Notices with be available and posted at our office(s) and posted on our web site, if applicable.

COMPLAINTS

If at any time you feel we have violated your HIPAA rights, please contact Clarity's Privacy Officer, 29 North Academy Street, Greenville, SC 29601 or (864) 331-1400, or with the Office of Civil Rights, US Department of Health and Human Services, 61 Forsyth St., SW, Suite 3B70, Atlanta, GA 30323. We will not retaliate against any individual for filing a complaint.

Date

PEDIATRIC
INITIAL QUESTIONNAIRE

Patient Name: ____________________ ____________________ ____________________ Date of Birth: ____________
Last First Middle Month/Day/Year

Questionnaire Completed by: ________________________________ Relation to Patient: ____________________

REFERRAL INFORMATION

Primary Care Physician: ____

Referring provider (if different from primary care physician): ______________________________________

What are your reasons for seeking help for the child at this time?

When did you first become concerned about the child?

What are the most positive features about the child?

FAMILY INFORMATION

Name of Parent 1: ______________________________ Name of Parent 2: ______________________________

Occupation: ______________________________ Occupation: ______________________________

Highest Grade Completed: ______________________ Highest Grade Completed: ______________________

Who does the child live with (include siblings and ages)? ______________________________________

If any immediate family members (for example, parent, sibling, etc.) are living elsewhere, please list:

Age	Sex	Relationship to this Child	Frequency of contact

Language(s) spoken/heard in the home: ____

Is the child adopted? □ No □ Yes

If yes, list date of adoption: ____

THIS IS A FOUR PAGE FORM

Clarity, Inc. | 29 North Academy Street | Greenville, SC 29601 | PH: 864-331-1400 | FAX: 864-331-1416

Patient Name: ______________________ ____________________ _________________ Date of Birth: _______________
Last First Middle Month/Day/Year

PREGNANCY HISTORY

Was the child's mother under doctor's care during the pregnancy? □ No □ Yes

During the pregnancy, did the mother take any medications or drugs (other than vitamins/iron), drink alcohol, or smoke cigarettes? □ No □ Yes

If yes, please describe: ____

Any complications during the pregnancy or delivery? □ No □ Yes

If yes, please describe: ____

Any specialized treatment provided to baby during and/or following delivery? □ No □ Yes

If yes, please describe: ____

Was the child born prematurely? □ No □ Yes If yes, what was the gestational age at delivery? ____weeks

Birth weight: ____lbs ___oz Length of hospital stay following delivery: _______ Mother _______ Baby

Did any of the following occur during your baby's first month of life?

□ Breathing Problems	□ Infection	□ Birth Defect	□ Excessive Vomiting
□ Jaundice (yellow)	□ Excessive Crying	□ Feeding Difficulty	□ Injury

DEVELOPMENTAL HISTORY

Communication/Speech/Language: Seems/ed early Seems/ed on time Seems/ed late

If concerns, please describe: ____

Motor Skills: Seems/ed early Seems/ed on time Seems/ed late

If concerns, please describe: ____

Do you have concerns for the child's social development? □ No □ Yes

If yes, please describe: ____

Do you have concerns for the child's emotional development? □ No □ Yes

If yes, please describe: ____

Do you have concerns for the child's behavior? □ No □ Yes

If yes, please describe: ____

Do you have any additional concerns for the child's development? □ No □ Yes

If yes, please describe: ____

Patient Name: ____________________ ____________________ ____________________ Date of Birth: ______________
Last First Middle Month/Day/Year

HEALTH HISTORY

Has the child had any of the following?

Convulsions, seizures, fainting spells? □ No □ Yes
If yes, please indicate when and describe: ______________________________

Vision or eye problems? □ No □ Yes

If yes, when was the last time the child's vision has been screened or evaluated? ______________________________

If yes, does the child wear glasses or contacts? □ No □ Yes (please specify) ______________________________

Hearing problems? □ No □ Yes

If yes, when was the last time the child's hearing has been screened or evaluated? ______________________________

If yes, does the child have hearing aid(s)? □ No □ Yes

Did the child pass their newborn hearing screening? □ No □ Yes

Recurrent ear infections? □ No □ Yes
If yes, please indicate when and describe: ______________________________

Have PE tubes been inserted? □ No □ Yes
If yes, at what age(s) and how many times? ______________________________

Allergies? □ No □ Yes
If yes, what is the child allergic to? ______________________________

Any surgeries, serious illnesses, injuries (including head injuries), or accidents? □ No □ Yes
If yes, please indicate when and describe: ______________________________

Has the child ever been hospitalized overnight? □ No □ Yes
If yes, when and why? ______________________________

Has the child ever been given a diagnosis? □ No □ Yes
If yes, please indicate when and state diagnosis(es): ______________________________

Please list any current health concerns: ______________________________

Is the child taking any medications? □ No □ Yes
If yes, please list: ______________________________

Does or has the child received any of the following services?			If yes, please describe (when, how long, what for):
BabyNet / Early Intervention	□ No	□ Yes:	______________________________
Speech/language therapy	□ No	□ Yes:	______________________________
Occupational therapy	□ No	□ Yes:	______________________________
Physical therapy	□ No	□ Yes:	______________________________
Counseling	□ No	□ Yes:	______________________________

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Patient Name: ______________ (Last) ______________ (First) ______________ (Middle) Date of Birth: ______________ (Month/Day/Year)

EDUCATIONAL HISTORY

Current School: ______________ Grade: ________ School District: ______________

What other schools has the child attended? (please list in chronological order beginning with nursery/preschool)

Are you worried about the child's school progress? ☐ No ☐ Yes
If yes, please describe: ______________

Does the child receive extra help at school? ☐ No ☐ Yes
If yes, please mark any supports the child has received:
☐ Tutoring (at school or privately) ☐ Small Group Intervention (such as, RtI or LLI) ☐ 504 Plan ☐ Special Education (IEP) ☐ Other ______________

Has the child ever had any testing done by the school system or elsewhere? ☐ No ☐ Yes
If yes, please describe: ______________

FAMILY HISTORY

	Is there a family history of the following?		If yes, list who has/d these concerns
Learning Difficulties	☐ No	☐ Yes:	
Reading	☐ No	☐ Yes:	
Written Language	☐ No	☐ Yes:	
Mathematics	☐ No	☐ Yes:	
Attention Problems	☐ No	☐ Yes:	
Hyperactivity/Impulsivity	☐ No	☐ Yes:	
Anxiety	☐ No	☐ Yes:	
Depression	☐ No	☐ Yes:	
Autism Spectrum Disorder	☐ No	☐ Yes:	
Intellectual Disability	☐ No	☐ Yes:	
Bipolar Disorder	☐ No	☐ Yes:	
Schizophrenia/Delusions/Hallucinations	☐ No	☐ Yes:	
Language/Speech Delay	☐ No	☐ Yes:	
Any Genetic Syndrome	☐ No	☐ Yes:	
Conduct Problems	☐ No	☐ Yes:	
Drug/Alcohol Problems	☐ No	☐ Yes:	
Seizure Disorder	☐ No	☐ Yes:	
Motor or Vocal Tics	☐ No	☐ Yes:	
Hearing Loss	☐ No	☐ Yes:	
Visual Problems	☐ No	☐ Yes:	
Muscular Problems/Weakness	☐ No	☐ Yes:	
Other (please specify)	☐ No	☐ Yes:	

Additional Comments: ______________

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____
Date

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PEDIATRIC AUDIOLOGY QUESTIONNAIRE

Patient Name: ____________________ ____________________ ____________________ Date of Birth: ______________
Last First Middle Month/Day/Year

Questionnaire Completed by: ______________________________ Relation to Patient: ____________________

REFERRAL INFORMATION

Referring provider (if different from primary care physician): ________________________________

What is the primary concern for this visit?________________________________

Do you have any concerns for your child's hearing?________________________________

Do you have any concerns for your child's speech?________________________________

Is there any family history of hearing loss?________________________________

Is there any family history of speech delay?________________________________

Has your child had any ear infections? □ No □ Yes If yes, when?________________________

Any complications during the pregnancy or delivery? □ No □ Yes
If yes, please describe: ________________________________

Was the child born prematurely? □ No □ Yes If yes, what was the gestational age at delivery? _____weeks

Birth weight: _____lbs ____oz APGAR scores:________________________________

Did any of the following occur during your baby's first two months of life?

□ Jaundice (yellow)	□ Infections	□ Physical abnormalities	□ High fever
□ Stayed in hospital longer than mother	□ Did not respond to sounds or people	□ Was in incubator or isolated	□ Used mechanical ventilation (5+ days)

Results of newborn hearing screening (circle one)? PASSED FAILED MISSED

Age your child sat up alone? _______________ Walked?________________ Said first word?________________

Has your child ever been diagnosed with any genetic, medical, or developmental delays/conditions? □ No □ Yes

If yes, please describe: ________________________________

Has your child ever had any head injuries, major illnesses (such as high fever), or hospitalizations? □ No □ Yes

If yes, please describe: ________________________________

Is your child taking any medications currently? □ No □ Yes

If yes, please list: ________________________________

If your child is in school, where do they attend school and what grade are they in? ______________________

THIS IS A ONE PAGE FORM

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WHAT IS A CENTRAL AUDITORY PROCESSING EVALUATION?

Central auditory processing (CAP) is, in essence, how the nervous system manages and interprets sound. It is best described as what the brain does with what the ears hear. We all have auditory processing skills, which we use, in varying amounts according to the situation. If these skills are poorer than normal, the listener may have difficulty understanding, remembering, or comprehending what is being said by someone else, depending on the circumstances.

To evaluate someone's central auditory processing abilities, a battery of several listening tests is used, and the performance of the test subject is compared to that of individuals with no known central auditory problems. These tests involve having the person being evaluated listen to speech, which is presented in unusual ways or in competition with noise. It is when the auditory system is stressed or taxed in this manner that a central auditory processing disorder shows up. Prior to the CAP portion of the test, a standard hearing test battery including tone thresholds, speech reception thresholds, speech discrimination testing without noise and tympanometry will be done. This must be done as close to the day of the CAP testing as is possible for two reasons. First the volume levels at which the CAP tests are given are based upon individual hearing levels. Variations of five decibels are common from day to day when human hearing is measured. Second, the effect of middle ear fluid on CAP tests is variable, and if conditions suggesting fluid are present at the time of testing, then the results are not quite as valid.

To prepare a child for central auditory processing testing, tell them that they will be wearing headphones (demonstrate this at home if you have a pair), and will be asked to listen and repeat some words. They will also be listening for small sounds (beeps) and will need to push a button when they hear it. It is usually fun to do this. There is no pain, discomfort, wires, electrodes, or needles involved. Depending on the child, testing takes about one hour with another half-hour immediately following to discuss preliminary results with the parents.

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To Whom It May Concern:

This is a brief description of the three tests included in the battery for assessing central auditory processing disorders. In addition to the audiometric evaluation, the three tests used were: **SSW (Staggered Spondaic Words), Speech-In-Noise, and Phonemic Synthesis Test.** A battery of tests is necessary since a CAP disorder cannot be diagnosed based on only one test. Three tests are usually considered the minimum number of tests necessary to make the diagnosis.

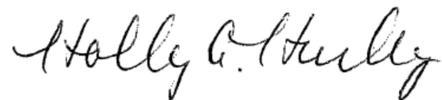
The **SSW Test** is a dichotic listening test. It's complicated scoring allows the examiner to analyze auditory memory skills as well as processing skills.

The **Speech-In-Noise Test** looks specifically at auditory figure-ground problems (problems hearing in background noise) by comparing monaural scores for quiet and +5 signal to noise ratio noise conditions for right and left ears separately.

The **Phonemic Synthesis Test** provides information about the individual's phonemic decoding skills (or ability to process on the speech sound level) as well as additional information about auditory memory skills and sequencing skills.

Norms are available for each of the tests for ages 5 through adult, and each of the above tests are analyzed based on the age-specific norms.

Sincerely,



Holly A. Hurley, M.S., CCC-A
Audiologist

Date: ______________________

RATING SCALE- IV:
HOME VERSION
(PEDIATRIC)

Patient Name: ______________________ (Last) ______________________ (First) ______________________ (Middle) Date of Birth: ______________________ (Month/Day/Year)

Questionnaire Completed by: ______________________ Relation to Patient: ______________________

Circle the number that *best describes* your child's home behavior over the past 6 months.

	Never or Rarely	Sometimes	Often	Very Often
1. Fails to give close attention to details or makes careless mistakes in schoolwork.	0	1	2	3
2. Fidgets with hands or feet or squirms in seat.	0	1	2	3
3. Has difficulty sustaining attention and tasks or play activities.	0	1	2	3
4. Leaves seat in classroom or in other situations in which remaining seated is expected.	0	1	2	3
5. Does not seem to listen when spoken to directly.	0	1	2	3
6. Runs about or climbs excessively in situations in which it is inappropriate.	0	1	2	3
7. Does not follow through on instructions and fails to finish work.	0	1	2	3
8. Has difficulty playing or engaging in leisure activities quietly.	0	1	2	3
9. Has difficulty organizing tasks and activities.	0	1	2	3
10. Is “on the go” or acts as if “driven by a motor”.	0	1	2	3
11. Avoids tasks (for example, schoolwork homework) that require sustained mental effort.	0	1	2	3
12. Talks excessively.	0	1	2	3
13. Loses things necessary for tasks or activities.	0	1	2	3
14. Blurts out answers before questions have been completed.	0	1	2	3
15. Is easily distracted.	0	1	2	3
16. Has difficulty awaiting turn.	0	1	2	3
17. Is forgetful and daily activities.	0	1	2	3
18. Interrupts or intrudes on others.	0	1	2	3