WICHITA STATE UNIVERSITY
COLLEGE OF HEALTH PROFESSIONS
Evelyn Hendren Cassat
Speech-Language-Hearing Clinic

Pediatric Audiology Case History

To be completed by a parent or guardian

IDENTIFYING INFORMATION:

Today's Date: _____

Client's Name (Please Print)

Last, First, MI: _____

Birthdate: _____/_____/_____ Age: _____

Primary care physician's name _____ Phone Number _____

Child lives with: ☐ both parents ☐ Mother ☐ Father ☐ other

Name of Person Giving Information: _____ Relationship: _____
Referred by: _____

FAMILY INFORMATION:

Parent(s) or Guardian(s) Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____ City: _____ Zip: _____

Email(s): _____

Names and Ages of other children in the family:

_____

_____

The following questions are designed to help us evaluate your child's auditory system. Please answer them as accurately and completely as possible. If a question does not apply please write NA.

1. What is the primary reason for this appointment?

_____

_____

2. Do you feel your child's hearing is stable or does it fluctuate? _____

3. Has he/she been diagnosed with any medical conditions or developmental disabilities?
□Yes □ No If yes, please list diagnoses

_____

4. Does your child have a history of ear infections? □Yes □ No
If yes, how many ear infections have they had? _____

5. Have tubes been placed in your child's ears or has your child had other ear surgeries?
□Yes □ No
If yes, how many sets of tubes or what type of ear surgery? _____

6. To your knowledge did your child pass their newborn hearing screening? □Yes □ No

7. Has anyone in your child's family been diagnosed with hearing loss before 30 years of age?
□Yes □ No
If yes, who in the family has a hearing loss and at what age? _____

8. Has your child's hearing been tested before by an audiologist? □Yes □ No
If yes when was the last hearing test? _____Where? _____
Results: _____

9. Does your child currently wear hearing aids? □Yes □ No
If yes, how old are the current aid(s)? _____

MEDICAL HISTORY:
Was any of the following present in your child's life? Please check all that apply

□Measles
□Meningitis
□Mumps
□ Allergies
□ Neonatal intensive care for more than 5 days
□ Hyperbilirubinemia (jaundice)
□ Anoxia (oxygen deprivation)
□ Ototoxic medications (e.g. gentamycin, aminoglycoside, loop diuretics)
□ Infections at birth or in utero (e.g. CMV, herpes, rubella, syphilis, taxoplasmosis)
□ Postnatal infections associated with hearing loss (e.g. herpes, meningitis)
□ Syndromes associated with hearing loss (e.g. neurofibromatosis, Usher syndrome, Waardenburg syndrome, CHARGE, Down syndrome)

ACADEMIC DEVELOPMENT:

1. Is your child in school? □Yes □ No Grade _____

2. How would you describe your child's academic performance/progress?

_____

3. In what area is your child having difficulty? _____

4. Where is your child seated in the classroom? _____

5. Does your child currently receive support services (including speech language therapy, occupational therapy, physical therapy, special education)? □Yes □ No

If yes please explain type of services _____

6. Does your child seem to have any of the following issues, please check all that applies?

- ☐ Problems following directions
- ☐ Distracted by background noise
- ☐ Oral and written expression problems
- ☐ Remembering what they hear
- ☐ Difficulty with multi-step directions
- ☐ Difficulty learning to read

PERMISSION FOR TEXT MESSAGES

I give permission for the Evelyn Hendren Cassat Speech Language Hearing Clinic to send me text messages for appointment reminders. I understand that message and data rates may apply, and that I may opt out by calling the clinic at 316-978-3289.

Patient Name: _____

Cell phone number: _____

Mobile phone carrier: _____

Signature: _____

WICHITA STATE UNIVERSITY
PATIENT/CLIENT EMAIL CONSENT FORM

PLEASE READ CAREFULLY. THIS FORM DISCUSSES THE RISKS OF USING EMAIL TO SHARE PERSONAL HEALTH INFORMATION.

As a patient or client of a Wichita State University Clinic, you may request that we communicate with you via unencrypted ele ctronic mail (email). This Fact Sheet will information of you the risks of communicating with your healthcare provider via email. Your health is important to us and we will make every effort to reasonably comply with your request to receive communications via email; however, we reserve the right to deny any request for email communications when it is determined that granting such a re quest would not be in your best interest.

WSU staff will make every effort to promptly respond to your requests for information via email; however, **IF YOU ARE EXPERIENCING AN EMERGENCY, YOU SHOULD NEVER RELY ON EMAIL COMMUNICATIONS AND SHOULD SEEK IMMEDI ATE MEDICAL ATTENTION.**

Risks of using email to send protected health information include, but are not limited to:

- Email messages sent or received by WSU are generally not encrypted and may not be secure.
- Third parties may therefore be able to intercept, read, alter, forward or use personal health information transmitted by email, without authorization or detection by you or WSU.
- An unsecure email message may be accidentally or intentionally forwarded to unintended recipients.
- Employers and internet service providers generally have the right to inspect and review any email message transmitted, received, or stored using their systems.
- Information shared by email may be printed, copied, and stored by any recipient in multiple locations.
- Copies of email messages containing personal health information may be kept, for example on backup servers or hard drives, long after the "original" message is deleted by both the sender and the recipient.
- Documents may be forged, and identities may be stolen to take advantage of these vulnerabilities.
- Your personal health information in WSU's records may include information relating to prescriptions and medications, communicable diseases, physical impairments, chronic conditions, genetics, behavioral and mental health services, alcohol and drug abuse or addiction, billing and payments, and other information related to your medical care and condition.
- WSU is not responsible for any unauthorized access to or use of your personal health information that results from any unencrypted transmission that you authorize.

PERMISSION TO ALLOW COMMUNICATIONS BY UNENCRYPTED EMAIL

By signing below, you acknowledge your recognition and understanding of the inherent risks of communicating your health information via unencrypted email and hereby consent to receive such communications despite those risks. Messages containing clinically relevant information may be incorporated into your medical record at the provider's discretion.

By signing below, you also acknowledge that you have the choice to receive communications via other more secure means. By sig ning below, you agree to hold Wichita State University harmless for unauthorized use, disclosure, or access of your protection hea lth information sent to the email address you provide.

Signature of Patient	Date
Printed Name of Patient	Email Address

Wichita State University
College of Health Professions
Evelyn Hendren Cassat Speech-Language-Hearing Clinic

WSU SPEECH LANGUAGE HEARING CLINIC FINANCIAL POLICY

PART 1: PATIENT INFORMATION

Fill out this form completely. Please print legibly.

Last Name:	First Name:	Middle Initial:
Date of Birth:		

PART 2: WSU SPEECH LANGUAGE HEARING CLINIC FINANCIAL POLICIES

1. The cost of services provided by WSU Speech Language Hearing Clinic is your responsibility, whether you are covered by health insurance or not. Payment is expected at the time of service unless arrangements have been made prior to treatment. WSU Speech Language Hearing Clinic accepts cash, checks and credit cards. **Please note: checks must be imprinted with the bank name and the account holder's name.** Scholarship opportunities may be available for pediatric clients. To inquire about eligibility, please call (316) 978-3166.

2. WSU Speech Language Hearing Clinic will process claims for any In Network Private Health Insurance Plans.

3. By giving WSU Speech Language Hearing Clinic your insurance information, you are authorizing WSU Speech Language Hearing Clinic to file a claim with (send a bill to) your insurance company for services rendered.

4. If you do not want WSU Speech Language Hearing Clinic to file a claim with your insurance company, you must notify WSU Speech Language Hearing Clinic at the time of your visit and pay in full any charges incurred at the time of the service.

5. Your insurance company may determine that some or all of the charges incurred at WSU Speech Language Hearing Clinic are not covered by your policy. It is your responsibility to know what your insurance covers and to ask questions prior to receiving services.

6. WSU Speech Language Hearing Clinic is not a contracting provider for and cannot bill KanCare, Medicaid, or Healthwave. If you have these types of government health benefits, you are responsible for paying all Speech Therapy and/or Audiology charges and it is your responsibility to seek reimbursement from these programs.

7. If you fail to pay any charges incurred within 6 months of services rendered, your outstanding charges will be sent to WSU Financial Services for collection. **Please note: if your account becomes past due, WSU Speech Language Hearing Clinic may discontinue providing services or goods until all past due amounts are paid**.

8. If you fail to pay any past due charges, WSU may refer your delinquent account to a third-party collection agency. You are responsible for paying the collection agency fee, together with all costs and expenses (including but not limited to reasonable attorney's fees and court costs) necessary for the collection of your delinquent account. You understand that your delinquent account may be reported to one or more of the national credit bureaus.

9. WSU Speech Language Hearing Clinic may charge late cancel and no-show fees if I do not cancel an appointment within notification times outlined on the WSU Speech Language Hearing Clinic website and/or in appointment reminder messages.

By signing below, I am agreeing that I:

1. Have read any understand the SHS Financial Policies as set forth above, and which may be amended from time to time;
2. Am financially responsible to pay for all services that I receive, whether covered by insurance or not;
3. Authorize WSU Speech Language Hearing Clinic to submit a claim (send a bill) to my health insurance company for services rendered and for consideration of payment and to release any medical or other information necessary to process the claim;
4. Authorize payment of my insurance benefits directly to Wichita State University; and
5. Authorize WSU Speech Language Hearing Clinic to file any mandatory reporting to the State of Kansas as required by state law

PART 3: SIGNATURE

Patient Signature _____ Date _____

Parent / Guardian Signature (if patient is under 18) _____ Date _____