ADULT AUDIOLOGY INFORMATION PACKET
DIAGNOSTIC EVALUATION

Cover letter
Driving Directions to CSHC
If you intend to seek insurance reimbursement
Patient Intake & Insurance Information
Case History Form
Consent to Treat

Telehealth Member Consent Form

FOR MEDICARE PATIENTS ONLY:
Medicare regulations governing outpatient rehabilitation services
Determining if Medicare is the primary payor

In order to be able to properly complete, save and resend, please adhere to the following steps:

1. Download and save to your computer 1st

2. Reopen the document and complete form

3. Save and then attach in an email to svitale@cshcga.com

4. *Print your name in signature blocks. Upon arrival at CSHC you will be asked to sign where needed.

In order to have a diagnostic appointment schedule, please either: 1) complete and email these forms to Samanta Vitale at svitale@cshcga.com, 2) hand deliver to our office, or 3) mail them back via USPS.

Upon receipt, and review, Chris will contact you to schedule an appointment. Thanks in advance for completing these forms, we look forward to seeing you in our office.

Columbus Speech & Hearing Center
2424 Double Churches Road
Columbus, Georgia 31909
(706) 324-6112 / (706) 596-8259 fax

To whom it may concern:

Your physician has referred you to Columbus Speech & Hearing Center for a speech/ language/ swallowing or occupational therapy evaluation.

In order to proceed with scheduling an appointment, please complete the enclosed documents and return them to us as soon as possible. When we receive the completed documents, we will contact you to schedule the evaluation appointment.

Please tell us the best way to contact you (check all that apply):

- Phone – give us the number to call _____
- Text – give us the number to text _____
- EMAIL – give us your email address _____
- Please tell us when it is best to contact you _____

- Text – **Opt in for TEXT reminders to avoid no-show and late fees**
  - ☐ I have opted in for TEXT reminders to be sent to me
  - ☐ I do not want TEXT reminders

If you have questions about scheduling, contact Sam Vitale at 706-324-6112, extension 203. Feel free to leave Same a voice message if she is not available.

Please note that once the evaluation appointment is scheduled this time is dedicated just for your child. If you need to cancel or change the appointment, please contact us 48 hours prior to the appointment to avoid a $50.00 rescheduling fee.

We look forward to seeing you soon.

Chris Weik cweik@cshcga.com
Front Office Supervisor
cweik@cshcga.com 706-324-6112 extension 230

Enclosed forms for your general information:

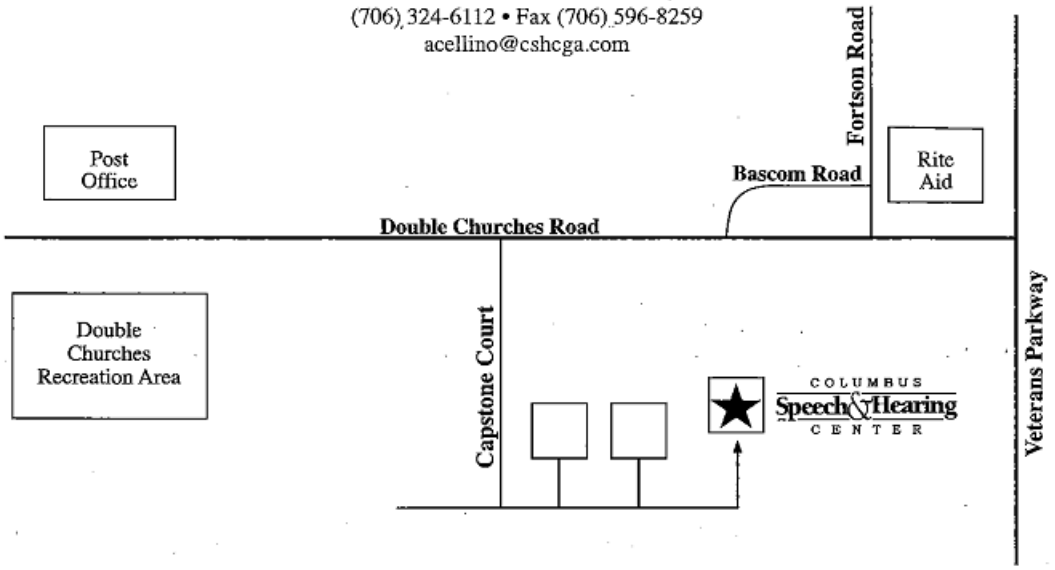
1. *This Cover Letter*
2. *Driving directions to Columbus Speech & Hearing Center*
3. *If You Intend to Seek Insurance Reimbursement*

Materials to return to Columbus Speech & Hearing Center before an initial visit is scheduled:

1. *Adult patient intake and insurance information form*
2. *Adult Audiology Case History Form*
3. *Consent to Treat*
4. *Telehealth Member Consent Form*
5. *Medicare only: Medicare regulations governing outpatient rehabilitation services*
6. *Medicare only: Determining if Medicare is the primary payor*

Directions to Columbus Speech & Hearing Center

COLUMBUS
Speech&Hearing
CENTER
2424 Double Churches Road • Columbus, GA 31909
(706) 324-6112 • Fax (706) 596-8259
acellino@cshcga.com



Coming from LaGrange/Atlanta (I-185 South)

- Take Williams Road, Exit 12
- Turn Left onto Williams Road
- Continue on Williams Rd for almost a mile
- Turn Right onto Fortson Road
- Stay on Fortson until you come to traffic light
- Turn Right onto Double Churches Rd
- Pass Palms Apts on Left; CSHC is next entrance on Left

Coming from Ft Benning (I-185 North)

- Take Exit 10 towards US-27/US-80/GA22/Macon/Phenix City, Al
- Keep Right to GA-22 East/US-80E ramp towards US-27 Macon
- Keep Right to take Veterans Pkwy ramp
- Turn Right on Veterans Parkway
- Cross over I-185; Turn Left onto Double Churches Road
- Pass North Lake Center and Palms Apts; take next entrance to Left to CSHC

Coming from East/Midland (JR Allen/US-80)

- Take Exit 4 towards I-185/Atlanta/Ft Benning
- Keep Right to US-27/GA-1/Veterans Pkwy ramp
- Go through traffic light onto Double Churches Road
- Pass North Lake Center and Palms Apts; take next entrance on Left

Coming from Phenix City (US 80 East)

- Take Exit 4 towards US-27/GA-1/Veterans Pkwy/Moon Road/I-185/Ft Benning/Atlanta
- Stay in Right lane and merge onto Veterans Pkwy/US-27 N/GA-1 toward Hamilton
- Turn Right onto Veterans Parkway
- Turn Left onto Double Churches Road
- Pass North Lake Center and the Palms Apts; take next entrance on the Left

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IF YOU INTEND TO SEEK INSURANCE REIMBURSEMENT

Columbus Speech & Hearing Center is an approved provider for multiple insurance companies. You should know that insurance companies frequently list speech therapy, audiology, and occupational therapy as reimbursable services, but that is not a guarantee of payment, particularly if the disorder is not due to a "medical" condition. Before your first visit, our staff will contact your insurance company and determine if the diagnostic evaluation is covered, if you have related deductible or co-pay. We will share that information with you before your visit here.

Before your first visit, we need:

1. Your physician to send us a prescription for a speech, language, occupation, balance and/or hearing evaluation. These scripts are faxed to our office (Fax: 706-596-8259)
2. A copy of your insurance card, front and back, if that presents a problem, you may provide that at your appointment
3. A completed *Patient Intake and Insurance Information* form, which is enclosed

If therapy is needed and you intend to seek insurance reimbursement:

1. Insurance companies typically require a written Diagnostic Evaluation, which we provide with a request for prior authorization of therapy. We notify you of their response before therapy starts.
2. Insurance companies may require periodic (usually on 6 month intervals) re-evaluations with progress reports. These entail additional reports, updated treatment plans, and staff time. Applicable fees are charged to the patient as "Additional services".
3. In general, we cannot negotiate with your insurance company on your behalf. In case of denials, we will provide any information they request, such as diagnostic reports or daily treatment notes. Will share all knowledge we have of what triggered the denial. If it is due to clerical error on our part, we will correct those errors and resubmit the claim. If it is due to the insurance company's coverage restrictions, we cannot negotiate with them on your behalf.
4. You are ultimately responsible for payment in full for any professional services rendered, regardless of your insurance status. Understand that prior authorization for a procedure is not always a guarantee of payment by the insurance company.

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ADULT PATIENT INTAKE AND INSURANCE INFORMATION

LAST NAME	*FIRST NAME*	*MI*	*BIRTHDATE*

PRIMARY CARE PHYSICIAN	*SOCIAL SECURITY NUMBER*	*SEX*

ADDRESS:
OCCUPATION:
EMPLOYER:
HOME PHONE: *CELL PHONE:* *WORK PHONE:*
EMAIL:

INSURANCE IDENTIFYING INFORMATION

	PRIMARY INSURANCE	*SECONDARY INSURANCE*
NAME OF INSURANCE		
NAME OF POLICY HOLDER		
RELATIONSHIP TO PATIENT		
POLICY NUMBER		
GROUP NUMBER		
PROVIDER CUSTOMER SERVICE NUMBER		
PLAN TYPE: HMO, POS, PPO		

PATIENT VERIFICATION OF ACCURATE INSURANCE INFORMATION AND RESPONSIBILITY FOR PAYMENT

I understand and agree that I am ultimately responsible for payment in full for any professional services rendered, regardless of my insurance status. The information listed above is true and accurate to the best of my knowledge. I understand that all claims are subject to individual contract policy and to medical necessity review. Prior authorization for a procedure is not a guarantee of payment. I will promptly notify you of any changes in my health care coverage or the above information.

I do hereby verify that this electronic signature is authentic (where applicable), and the information herein is being submitted by me.

*s/s*_____ _____

**Patient signature* *Date*

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Adult Audiology Case History

Name_____ Birthdate_____Today's Date:_____
How did you hear about us?_____Name of spouse or friend with you today?_____
Referral source: _____To whom should reports go: _____

Check any of the following that you currently have, or have had:							
High blood pressure	☐	Heart disease	☐	Stroke	☐		
Arthritis	☐	Diabetes	☐	Kidney disease	☐		
Cancer	☐	Mumps	☐	Measles	☐		
Meningitis	☐	General anesthetic	☐	Head Trauma	☐		

1. List any chronic illnesses: _____
2. List all current medications: _____
3. How is your current health? _____
4. Was the onset of your hearing loss sudden or gradual? _____
5. Who first noticed your hearing problem?_____When?_____
6. Describe any medical treatment you may have had for your hearing problem: _____
7. In which ear do you hear better? ☐ Left ☐ Right
8. Do you have tinnitus (ringing, buzzing, hissing) sounds in your ear? Yes☐ No☐
9. In which ear does it occur? Left☐ Right☐ Both☐
10. When did you first notice it? 1-3 years☐ 4-10 years☐ More than 10 years☐
11. How often does your tinnitus occur? _____
12. When was the last time you had your hearing tested? _____Where? _____
13. Why have you decided to have your hearing tested at this time?
    - ☐ a. I feel my hearing is poor and may need to be aided
    - ☐ b. Family/friends have suggested I have my hearing tested.
    - ☐ c. Other/explain:
14. If you wear hearing aids:
    a. In which ear? Left only☐ Right only☐ Both ears☐
    b. When did you buy your hearing aids?_____
    c. Approximately how many hours a day do you wear them? _____
    d. Do you have any problems with your aids? ☐ If Yes, explain: _____

Yes	No	***Please check yes or no. For "Yes" answers to the following questions, please explain***
☐	☐	*Have you been exposed to loud noise for long periods of time?*
☐	☐	*Does anyone in your family have hearing loss?*
☐	☐	*Do you have dizziness, vertigo or loss of balance?*
☐	☐	*Have you ever worn a hearing aid?*
☐	☐	*Did you have chronic ear infections as a child or adult?*
☐	☐	*Do your ear canals itch?*
☐	☐	*Have you had any falls within the last 12 months? If so how many?*
☐	☐	*Do you use tobacco products? If so how often?*
☐	☐	*Do you have tubes or holes in your eardrum?*
☐	☐	*Do you have sinus or allergy problems?*
☐	☐	*Do you have pain or discomfort in your ears?*
		Do you have difficulty when:
☐	☐	*a. Someone speaks in a whisper?*
☐	☐	*b. Visiting friends, relatives or neighbors?*
☐	☐	*c. Listening to TV or radio?*
☐	☐	*d. Listening to children or women?*

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CONSENT TO TREAT SIGNATURE PAGE

Patient Name: DOB: Age: Account:

Instructions: Please **initial** beside each of the following items, indicating your authorization or agreement.

Date	Yes, I agree	No, I do not agree	
			CONSENT FOR TREATMENT: I hereby consent to such diagnostic procedures, and medical treatment, which in the judgment of my Physicians may be considered necessary or advisable while a patient at Columbus Speech and Hearing Center
			ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Columbus Speech & Hearing Center of the Medical Benefits, otherwise payable to me for services described above, but not to exceed reasonable and customary charges for those services. I understand and acknowledge that this assignment does not relieve me of my financial responsibility. If payment has not been received from the insurance carrier, *I accept personal liability for the charges not reimbursed by Insurance within 45 days.*
			AUTHORIZATION TO RELEASE INFORMATION: I consent to the release of relevant diagnostic, therapy , or other related materials to qualified professional personnel in furtherance of clinical services on behalf of me or my minor being seen; or for whom I am legally responsible, as deemed medically necessary by the attending Speech-Language Pathologist and/or Audiologist at Columbus Speech and Hearing Center.
			ACKNOWLEDGEMENT OF RECEIPT OF *NOTICE OF PRIVACY PRACTICES* (you may refuse to sign this acknowledgement) I have received a copy of this office's *Notice of Privacy Practices.*

I do hereby verify that the following electronic signature(s) are authentic and the information herein is being submitted by me.

_____ _____ _____

*Patient Signature Date Witness

MEDICARE OR MEDICAID AS SECONDARY INSURANCE

I am aware that I am personally responsible for any and all Medicare co-pays, co-insurance, and deductibles for Speech and/or Hearing evaluations or therapy. I am aware that Columbus Speech and Hearing Center cannot bill Medicaid for services rendered on patients over 21 years of age. I agree to pay all monies due to Columbus Speech and Hearing Center at the time services are rendered or upon receipt of an invoice for services rendered by Columbus Speech and Hearing Center.

_____ _____ _____ _____

Patient Name Date *Parent/Guardian Signature Witness

FOR OFFICE USE ONLY

We have attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices*, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

Rev 2-5-2020

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Telehealth Member Consent Form

PATIENT NAME: _____

DATE OF BIRTH: _____

INSURANCE/MEMBER ID: _____

1. **PURPOSE:** The purpose of this form is to obtain your consent to participate in a telehealth consultation in connection with one or a combination of the following service(s):

   Speech, Audiology, and/or Occupational Therapy

2. **NATURE OF TELEHEALTH CONSULT:** During the telehealth consultation:
   a. Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.
   b. A physical examination of you may take place.
   c. A non-medical technician may be present in the telehealth studio to aid in the video transmission.
   d. Video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s).
3. **MEDICAL INFORMATION & RECORDS:** All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telehealth interaction to researchers or other entities shall not occur without your consent.

4. **CONFIDENTIALITY:** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth consultation, and all existing confidentiality protections under federal and Georgia state law apply to information disclosed during this telehealth consultation.

5. **RIGHTS:** You may withhold or withdraw consent to the telehealth consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

6. **DISPUTES:** You agree that any dispute arriving from the telehealth consult will be resolved in Georgia, and that Georgia law shall apply to all disputes.

7. **RISKS, CONSEQUENCES & BENEFITS:** You have been advised of all the potential risks, consequences, and benefits of telehealth. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telehealth consultation. All your questions have been answered, and you understand the written information provided above.

I agree to participate in a telehealth consultation for the procedure(s) described above.

Signature:_____ Date: _____

If signed by someone other than the patient, indicate relationship: _____

Witness Signature: _____ Date: _____

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MEDICARE REGULATIONS GOVERNING OUTPATIENT REHABILITATION SERVICES

To insure maximum coverage for your speech and hearing rehabilitation and avoid any misunderstandings, there are several ***Medicare Regulations*** of which you should be aware.

- Medicare has an annual cash deductible which must be met before your coverage is effective. If this amount is paid during the last three months of the year, the amount paid during that period will be carried forward and applied to the up-coming year's deductible amount.
- Medicare outpatient coverage is 80% of reasonable charges. You are responsible for paying the other 20%. For children under 21 years of age who qualify for Medicaid, the 20% co-insurance portion is paid by Medicaid. Secondary insurance policies may pay the 20% co-pay. This should be confirmed in advance with our billing department.
- You (Medicare patient) can be accepted for outpatient speech pathology therapy, or audiological testing, or occupational therapy only on the written referral of your physician.
- Your attending physician will receive a copy of your initial evaluation report and Plan of Care within 10 days of your initial visit here.
- Subsequent Updated Plans of Care are forwarded to your attending physician every 30 days.
- Re-certification of continued need by the attending physician and therapist must be documented every 90 days.
- You must be under the care of your attending physician with his/her reports of his/her findings incorporated into your clinic file (speech, hearing, occupational therapy)
- Forms to be completed by your attending physician will be mailed to your doctor or given to you at the appropriate time.

To insure continued re-certification, your responsibilities are to:

1. Inform your physician of your desire to receive speech-language, audiology, or audiology services, thereby insuring his/her support.
2. Arrange for a regular check-up with your physician, hand carry your re-certification form to your physician. This will allow him/her to review your progress and re-certify your continued need for treatment. Return the above signed re-certification to your clinician at your next therapy visit.

I have read, understand, and agree to abide by the above regulations.

I do hereby verify that this electronic signature is authentic (where applicable), and the information herein is being submitted by me.

_____ _____ _____ _____

*PATIENT SIGNATURE DATE WITNESS DATE

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FOR MEDICARE PATIENTS ONLY - DETERMINING IF MEDICARE IS THE PRIMARY PAYOR:

QUESTION	NO	YES	
1. Is the patient 65 or older? 2. Is the patient employed? 3. Is the patient covered by an Employer's Group Health plan? 4. Does patient's employer have >100 employees?			If Yes to # 3, list the name, address and ID # on the card
1. Is the patient's spouse employed? 2. If YES, does the spouse have dependent coverage on his/her Group Health Insurance? 3. Does spouse's employer have 20 or more employees?			If Yes to # 2, list the name, address and ID # on the card
1. Is the patient a disabled Medicare beneficiary? 2. Is injury/illness due to a work related accident? 3. Is injury/illness due to an automobile or liability accident?			If Yes to # 3, explain
1. Does the patient suffer from kidney failure? 2. Does patient have Veterans' Administration benefit coverage? 3. Does patient have any other insurance coverage that will pay for therapy before Medicare eg COBRA?			If Yes to # 3, list the name, address and ID # on the card

By answering the preceding questions, I have established Medicare as the primary/secondary payor (circle one). If Medicare is primary, I understand that I am responsible for any deductibles and coinsurance. If Medicare is secondary, I understand that Columbus Speech & Hearing Center will file my primary insurance before filing Medicare.

I do hereby verify that this electronic signature is authentic (where applicable), and the information herein is being submitted by me.

_____ _____

*PATIENT SIGNATURE DATE

Thank you for completing these form. Please save and email them to our front office manager Chris Weik at cweik@cshcga.com