HASA
CIRS Interpreting @ Gateway School
Hearing and Speech-Language Services

Fluency History

Date: _____

Name: _____

Address: _____
Street Address, Apt. # City, State Zip

Email Address: _____

Telephone: Home: _____ Work: _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female

Marital Status: _____ Social Security Number: _____

Emergency Contact:

_____

Address: _____
Street Address, Apt. # City, State Zip

Email Address: _____

Telephone: Home: _____ Work: _____

Referred by:

_____

Educational Level: _____ Occupation: _____

Employed by:

_____

Address:

_____

List and describe all members of your present family living in your home and any speech, hearing, or language problems present.

Name	Relationship	Communication Problem

Current Health Status: (Check Yes or No; explain more fully when appropriate)

Are you currently in good health? ☐ Yes ☐ No_____

Is your hearing good? ☐ Yes ☐ No_____

Do you wear hearing aids? ☐ Yes ☐ No_____

Is your vision good? ☐ Yes ☐ No _____

Are you ambulatory? ☐ Yes ☐ No_____

Are you currently taking medications? ☐ Yes ☐ No List:_____

Patient History

Do you have any associated medical pathology (ex., cleft palate, cerebral palsy, post-CVA, accident or injury) that may be contributing to your stuttering problem?

☐ Yes ☐ No If so, please explain. _____

_____

_____

_____

Have you been hospitalized within the past year? ☐ Yes ☐ No
If so, may we contact your hospital for your discharge summary?
(Sign)

_____

Name of Hospital: _____

In order to help you, it may be appropriate to send reports to or contact other agencies or professional persons for information. Please indicate your permission by signing below.

I authorize and request _____ *(Clinic name and address)* ***to obtain and/or exchange pertinent medical/educational information. It is understood that all information is kept confidential.***

Sign: _____ Date: _____

If signed by a person other than the client, please give name and relationship of that person.

_____

Your Speech, Language, or Hearing Problem

Why are you seeking help at this time? _____

_____

_____

How long have you had this problem? _____

Have you ever received treatment? ☐ Yes ☐ No
If so, where? _____ How long? _____

Describe the strategies that helped:

_____

_____

_____

_____

_____

What does your stuttering sound like to you? _____

☐ Repeated Sounds ☐ Words ☐ Prolonged Sounds
☐ Holding breath ☐ Sounds get stuck

When is the problem better? _____

_____

_____

When is the problem worse?

_____

_____

_____

What do you think caused the problem? _____

_____

_____

How do you feel about the problem? _____

_____

_____

_____

Do you avoid speaking at times? ☐ Yes ☐ No (Please explain) _____

What are the reactions of others to the problem? _____

Does the problem affect your ☐ job ☐ school performance (Please explain) _____

Patient History

Does any member of your family have similar problems? ☐ Yes ☐ No (Please explain)

In the space below, please provide us with any information that may be useful in evaluating your communication and planning a treatment program:

_____ _____

Form Completed by Date

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FINANCIAL INFORMATION

Financially Responsible Party If Other Than the Patient

Name:_____ Relationship to Patient:_____

Address:_____

Home Phone:_____ Cell Phone:_____

Primary Insurance Information for Policy Holder

Insurance Company:_____ Policy/ID Number (include alpha prefix):_____

Group Number: (include alpha characters) _____Effective Date:_____

Claims Phone Number:_____ Policy Holder Name:_____

Date of Birth:_____ Social Security Number:_____

Relationship to Patient:_____ Employer:_____

Work Phone:_____

Secondary Insurance Information for Policy Holder

Insurance Company:_____ Policy/ID Number (include alpha prefix):_____

Group Number: (include alpha characters) _____Effective Date:_____

Claims Phone Number:_____ Policy Holder Name:_____

Date of Birth:_____ Social Security Number:_____

Relationship to Patient:_____ Employer:_____

Work Phone:_____

Form Completed by:_____ **Relationship to Patient:**_____

Signature:_____ **Date:**_____

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Permission to Obtain & Release Information

Client Name_____ Date of Birth_____

Please note that per Medicaid guidelines, we must release all evaluation and treatment notes to your child's pediatrician.

If you would like for your child's evaluation and progress notes to be sent to an additional physician, please list below:

Physician Name _____

Physician Address_____

Phone Number _____ Fax Number_____

I hereby authorize The Hearing and Speech Agency of Metropolitan Baltimore, Inc. to obtain/release pertinent clinical and/or educational information in written and/or oral form regarding evaluation, treatment, or ongoing progress for the above-named person, in the following disciplines:

☐ Audiology ☐ Education ☐ Medical ☐ Occupational Therapy

☐ Psychology ☐ Social Work ☐ Speech-Language Pathology ☐ Other

If you do not have Medicaid, your child's notes will automatically be sent to the physician on file unless otherwise noted.

☐ I do not want my information or records released to anyone.

_____ _____
Client (Parent or Guardian if client is a minor) Date

_____ _____
Witness Date

This consent will be in effect for one year from the date of signature. It may be revoked or revised in writing at any time by the person giving permission on this form or by a minor child who reaches the age of majority during the effective year.

THE HEARING AND SPEECH AGENCY
Harry & Jeanette Weinberg Building | 5900 Metro Drive | Baltimore, MD 21215 | www.hasa.org
(p) 410.318.6780 | MD RELAY 711 | (f) 410.318.6759 | (e) hasa@hasa.org

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CONSENT FOR TREATMENT:
I hereby authorize the personnel of The Hearing and Speech Agency and Hilgenberg Scottish Rite Center to render to the patient whose name appears on this form such care as they deem necessary and appropriate.

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize The Hearing and Speech Agency and Hilgenberg Scottish Rite Center to release my diagnosis and other medical information to the third party payer identified to determine benefits payable. Reports will be sent to me electronically or via fax unless otherwise noted. **Please remove The Hearing and Speech Agency from your SPAM folder**.

ASSIGNMENT OF BENEFITS:
I hereby authorize direct payment to The Hearing and Speech Agency of any insurance otherwise payable to me or the patient. I acknowledge the responsibility for any coinsurance, deductible, and/or other sum not received by The Hearing and Speech Agency from any third party source.

GUARANTEE OF PAYMENT:
I acknowledge financial responsibility for any health insurance deductible, coinsurance or failure for any reason of any insurance carrier to pay The Hearing and Speech Agency's charge in full when rendered. Once the bill has been submitted to the insurance company, changes to procedures or diagnostic codes cannot be made. I also acknowledge that interest may be charged to unpaid balances over 30 days from the date payment is due. In the event that the account is referred for collections, I agree to pay for all collection and attorney fees required to collect any delinquent balance.

PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION (Applies to Medicare Patients Only):
I hereby certify that the information given by me applying for payment under TITLE XVIII and XIX of the Social Security Act of third party payers is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim.

PERSONAL VALUABLES:
Patients are encouraged to leave all valuables at home. The Hearing and Speech Agency is not responsible for the loss of or damage to any personal property the patient has brought into The Hearing and Speech Agency.

PATIENT RIGHTS AND RESPONSIBILITIES:
I have been notified about patient rights and responsibilities including Privacy Practices.

I permit a copy of this authorization to be used in place of the original.

I certify that I understand the contents of this form.

Client Name	Guardian Name	Client/Guardian Signature	Date