HARRIS AUDIOLOGY, LLC

# Pediatric Intake Form

Welcome to Harris Audiology. Please complete the following pediatric intake form to help us understand your child's hearing health history and provide the best possible care.

## Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

School of Attendance: _____ Grade: _____

Race: _____ Ethnicity: _____

Does child have: ☐ IEP ☐ 504 Gender Identity: ☐ M ☐ F Other:_____

## Parent/Guardian Information

Name(s): _____ Email: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____

Who else lives at home with the child?

_____

## Contact Preferences

How should I contact you?

☐ Email
☐ Text
☐ Phone Call
Is it alright to leave a Voicemail: ☐ YES ☐ NO

Best time of day to contact you?

☐ Morning
☐ Afternoon
☐ Evening (After 5PM)

## Referral Information

Referring Physician/Teacher/Specialist : _____

Contact Information: _____

Reason for Referral: _____

HARRIS AUDIOLOGY, LLC

# Pediatric Intake Form

## Medical History

Has your child ever been diagnosed with:

☐ Ear Infections?
☐ Hearing Loss?
☐ Other ear related conditions?
If yes, please explain: _____

Does your child have a history of:

☐ Premature birth?
☐ NICU stay?
☐ Jaundice requiring treatment?
If yes, please explain: _____

List any surgeries or hospitalizations:

List any current medications:

## Developmental History

At what age did your child?

Babble? _____
Say their first word? _____
Combine words into sentences? _____

At what age did your child?

Sit without support? _____
Crawl? _____
Walk? _____

Does your child interact well with others? Are there concerns with attention, focus, or behavior?

## Hearing History

Does your child react to loud sounds?

☐ YES
☐ NO
Explain: _____

Has your child ever failed a hearing screening?

☐ YES
☐ NO
Date of Last Evaluation: _____

Does the child have a diagnosed hearing condition?

☐ YES
☐ NO
If yes, specify:
**Hearing Loss:** _____
(e.g., mild, moderate, severe, profound)

**Type:** _____
(e.g., conductive, sensorineural, mixed)

Does the child use hearing aids or cochlear implants?

☐ YES
☐ NO
If yes, specify:
**Device Type:** _____

**Duration of Use:** _____

HARRIS AUDIOLOGY, LLC

# Pediatric Intake Form

## Educational and Social Information

Is your child currently in school or daycare?

☐ YES ☐ NO

School Name? _____

Grade? _____

Does your child receive any special services?

☐ Speech Therapy?
☐ Occupational Therapy?
☐ Behavioral Therapy (ABA)?

Other: _____

Are there any teacher or caregiver concerns about the child's listening or comprehension?

_____

Does the child have difficulty communicating with friends/family members?

☐ YES ☐ NO

Primary language(s) spoken at home: _____

Are you in need of additional educational support for your child's IEP, 504?

☐ YES ☐ NO

## Auditory and Communication Information

Does the child exhibit difficulty with the following:

Hearing in noisy environments: ☐ YES ☐ NO
Following multi-step instructions: ☐ YES ☐ NO
Understanding fast or complex speech: ☐ YES ☐ NO
Remembering verbal instructions: ☐ YES ☐ NO
Differentiating between similar sounds (e.g., cat vs. hat): ☐ YES ☐ NO

Does the child appear distracted or overwhelmed by auditory input? ☐ YES ☐ NO

Is there a history of delayed speech or language development?
☐ YES ☐ NO

Does anyone in your family have hearing loss?

_____

Is there any additional information you feel would help us understand and support your child better?

_____

## About

Harris Audiology LLC wants you to be aware of the Federal Government rules and regulations that are in place to protect your health information. Harris Audiology LLC is committed to helping you understand these rules and regulation so that we can most effectively treat you.

Harris Audiology LLC provides documents that tell you how information that may identify you and that relates to your audiological/health care will be used. Some of these documents must be signed by you to show you received and understand them and to enable the highest level of care by Harris Audiology LLC.

This pamphlet provides an overview of the documents you will receive from Harris Audiology LLC.

## Notice of Privacy Practices

The Notice of Privacy Practices is a lengthy document that goes into detail to fully inform you about how your health information is used. In a nutshell, the Notice of Privacy Practices covers the following topics:

- How Harris Audiology LLC manages and protects your health information.
- How you can restrict certain uses and disclosures of your protected health information
- Your rights in requesting information about your protected health information; and
- Contact information if you have any questions or concerns regarding your protected health information.
- Harris Audiology LLC requests that you sign an acknowledgement that you received the Notice of Privacy Practices.

## Authorization to Use and Disclosure

To assist Harris Audiology LLC in providing the best care possible and to communicate with those close to you and other health professionals that may be treating you, Harris Audiology LLC provides you a form to let us know who we can share your health information with.

## Marketing Authorization

The marketing authorization form authorizes Harris Audiology LLC to contact you with various product and/or treatment options related to your audiological/health care. Harris Audiology LLC may receive compensation for these communications. The authorization form gives you the option of either:

- Authorizing all marketing communications.
- Requiring authorization for any one marketing communication.
- Prohibiting any marketing communication.

## Questions/Comments

Please do not hesitate to ask us any questions you may have about your protected health information. You may contact our Privacy Officer, Kylie Harris, harrisaudiology@gmail.com, 334-333-2832.

## Acknowledgement of Receipt of Notice of Privacy Practices

☐ By checking this box and signing below, I acknowledge that I received a copy of Harris Audiology LLC's Notice of Privacy Practices.

The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice.

I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

| | |
|---|---|
| **Printed name of patient or personal representative** | **Date** |
| **Printed name of patient or personal representative** | **Date** |

**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.**

## ABOUT THIS NOTICE

Harris Audiology LLC is committed to protecting your health information. This Notice of Privacy Practices ("Notice") is provided pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as revised in the 2013 HIPAA Omnibus Rule. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or audiological/health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights and our duties with respect to your protected health information.

"Protected health information" is information about you that may identify you and that relates to your past, present or future physical or mental health/condition and related audiological/healthcare services. We must follow the privacy practices that are described in this Notice while it is in effect. If you have any questions about this Notice, please contact our Privacy Officer, Kylie Harris, harrisaudiology@gmail.com, 334-333-2832.

## HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe the different ways that we may use and disclose your protected health information. These examples are not meant to be exhaustive, but to illustrate the types of uses and disclosures that may be made.

### 1. Treatment

We may use and disclose your protected health information to provide, coordinate, or manage your audiological treatment and any related services. We may also disclose your protected health information to other third party providers involved in your audiological/health care. For example, your protected health information may be provided to a physician or other audiological/healthcare provider (e.g. a specialist or laboratory) to whom you have been referred to ensure that the physician or other audiological/health care provider has the necessary information to diagnose or treat you.

### 2. Payment

We may use and disclose your protected health information so that the treatment and health care services you receive may be billed to you, your insurance company, a government program, or third party payors. This may include certain activities that your health insurance plan may undertake before it approves or pays for the audiological/health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may provide your health plan with medical information about the audiological/health care services Harris Audiology LLC rendered to you for reimbursement purposes.

### 8. Public Health

We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

### 9. Business Associates

We may disclose your protected health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. To protect your health information, however, we require the business associate to appropriately safeguard your information.

### 10. Communicable Diseases

We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

### 11. Health Oversight

We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the audiological/health care system, government benefit programs, other government regulatory programs and civil rights laws.

### 12. Abuse or Neglect

We may disclose your protected health information to a public health authority that is authorized by law to receive reports of abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

### 13. Food and Drug Administration

We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required by law.

### 14. Legal Proceedings

We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request or other lawful process.

### 15. Law Enforcement

We may disclose your protected health information, so long as applicable legal requirements are met, for law enforcement purposes.

### 16. Coroners, Funeral Directors, and Organ Donation

We may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose your protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out its
duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

### 17. Research

We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

### 18. Serious Threat to Health or Safety

Consistent with applicable federal and state laws, we may disclose your protected health information to prevent or lessen a serious threat to your health and safety or to the health and safety of another person or the public.

### 19. Military Activity and National Security

If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your protected health information to authorized officials so they may carry out their legal duties under the law.

### 20. Workers' Compensation

We may disclose your protected health information as authorized for workers' compensation or other similar programs that provide benefits for a work-related illness.

### 21. For Data Breach Notification Purposes

We may use or disclose your protected health information to provide legally required notices of unauthorized access to or disclosure of your health information.

### 22. Required Uses and Disclosures

Under the law, we must make disclosures to you and when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. Seq.

## SPECIAL PROTECTIONS FOR HIV, ALCOHOL AND SUBSTANCE ABUSE, MENTAL HEALTH AND GENETIC INFORMATION

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. Some parts of this Notice may not apply to these types of information.

## USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION

The following uses and disclosures will be made only with your written authorization:

1. Uses and disclosures of protected health information for marketing purposes for which we or a business associate may receive remuneration; and
2. Disclosures that constitute a sale of protected health information.

Other uses and disclosures of your protected health information not described in this Notice will be made only with your written authorization, unless otherwise permitted or required by law.

You may revoke this authorization, at any time, in writing, except to the extent that Harris Audiology LLC has taken an action in reliance on the use or disclosure indicated in the authorization. Additionally, if a use or disclosure of protected health information described above in this Notice is prohibited or materially limited by other laws that apply to use, it is our intent to meet the requirements of the more stringent law.

## YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

### 1. Right to be Notified if there is a Breach of Your Protected Health information

You have the right to be notified upon a breach of any of your unsecured protected health information.

### 2. Right to Inspect and Copy

You may inspect and obtain a copy of your protected health information that is contained in your medical and billing records and any other records that Harris Audiology LLC uses for making decisions about you. To inspect and copy your medical information, you must submit a written request to our Privacy Officer, Kylie Harris, 1733 West Main Street, Suite 100, Dothan, Alabama 36301. If you request a copy of your information, we may charge you a reasonable fee for the costs of copying, mailing or other costs incurred by us in complying with you request. Under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, we may deny your request to inspect and/or copy your protected health information. A decision to deny access may be reviewable. Please contact our Privacy Officer, Kylie Harris, harrisaudiology@gmail.com, 334-333-2832 if you have questions about access to your medical record.

### 3. Right to Request Restrictions

You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. To request a restriction on who may have access to your protected health information, you must submit a written request to our Privacy Officer, Kylie Harris, 1733 West Main Street, Suite 100, Dothan, Alabama 36301.

Your request must state the specific restriction requested and to whom you want the restriction to apply. Harris Audiology LLC is not required to agree to a restriction that you may request, unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment or audiological/health care operation purposes and such information you wish to restrict pertains solely to a audiological/health care item or service for which you have paid us "out-of-pocket" in full. If we believe it is in your best interest to permit the use and disclosure of your protected health information, your protected health information will not be restricted. If we do agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

### 4. Right to Request Confidential Communication

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. You must request this by submitting a written request to our Privacy Officer, Kylie Harris, 1733 West Main Street, Suite 100, Dothan, Alabama 36301.

### 5. Right to Request Amendment

You may request an amendment of your protected health information contained in your medical and billing records and any other records that Harris Audiology LLC uses for making decisions about you, for as long as we maintain the protected health information. You must request for an amendment by submitting a written request to our Privacy Officer, Kylie Harris, 1733 West Main Street, Suite 100, Dothan, Alabama 36301, and provide the reason(s) that support your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

### 6. Right to an Accounting of Disclosures

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. You must request for an accounting of disclosures by submitting a written request to our Privacy Officer, Kylie Harris, 1733 West Main Street, Suite 100, Dothan, Alabama 36301, and provide the reason(s) that support your request.

### 7. Right to Obtain a Paper Copy of this Notice

You have the right to receive a paper copy of this Notice even if you have agreed to receive this notice electronically. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this Notice, you can contact our Privacy Officer, Kylie Harris, harrisaudiology@gmail.com, 334-333-2832.

## COMPLAINTS OR QUESTIONS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. If you have a question about this Notice or wish to file a complaint with us, please contact our Privacy Officer, Kylie Harris, harrisaudiology@gmail.com, 334-333-2832 or the Corporate Privacy Officer at the address listed below. All complaints must be submitted in writing. Harris Audiology LLC will not retaliate against you for filing a complaint.

## CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time. The new Notice will be effective for all health information we already have about you as well as any information we receive in the future. You can also obtain a revised Notice by contacting our Privacy Officer, Kylie Harris, 1733 West Main Street, Suite 100, Dothan, Alabama 36301.

Harris Audiology LLC
Attn: Corporate Privacy Officer

**This Notice is effective as of April, 2013.**

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Social Security #: _____ Phone #: _____

I acknowledge that I received a copy of Harris Audiology LLC's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, the website (if applicable) and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

• This Notice informs me how Harris Audiology LLC will use my health information for the purposes of my treatment and/or payment for my treatment.

• This Notice explains in more detail how Harris Audiology LLC may use and share my health information for other than treatment, payment, and health care operations.

• Harris Audiology LLC will also use and share my health information as required/permitted by law.

_____ _____

**Printed name of patient or personal representative** **Date**

_____ _____

**Printed name of patient or personal representative** **Date**

# AUTHORIZATION AND RELEASE FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR MARKETING

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Social Security #: _____ Phone #: _____

I authorize Harris Audiology LLC to use/disclose my protected health information for marketing related to audiological/health-related products or services. I understand that Harris Audiology LLC or its business associates may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described.

I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

☐ I Authorize Harris Audiology LLC to use and disclose medical information for any and all marketing purposes and understand that Harris Audiology LLC or its business associate may receive financial remuneration in exchange for making the marketing communication for on behalf of the third party whose product or service is being described. A list of anticipated and potential persons/class of persons/organizations to whom information may be disclosed is included below.

☐ I request an Authorization form for each instance Harris Audiology LLC intends to use and disclose medical information for any marketing purposes and understand that Harris Audiology LLC or its business associate may receive financial remuneration in exchange for making the marketing communication or on behalf of the third party whose product or service is being described.

☐ I prohibit Harris Audiology LLC from using and disclosing medical information for any marketing purposes.

A list of anticipated and/or potential persons/class of persons/organizations to whom information may be disclosed:

_____

_____

# Marketing Authorization

If you need assistance in completing the authorization form, please contact Kylie Harris, harrisaudiology@gmail.com.

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Harris Audiology LLC.

I understand that this authorization is in effect for the term set forth below or until the revocation section of this form is signed and received. I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to **Harris Audiology LLC.**

I authorize Harris Audiology LLC's use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Harris Audiology LLC cannot condition my treatment, services, etc. on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

_____ _____

**Printed name of patient or personal representative** **Date**

_____ _____

**Printed name of patient or personal representative** **Date**

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## EXPIRATION/REVOCATION SECTION

Expiration: This authorization will expire on (must choose one):

☐ One year from the date it is signed
☐ Other (insert date or event): _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.

I hereby revoke this authorization.

_____ _____

**Printed name of patient or personal representative** **Date**

_____ _____

**Printed name of patient or personal representative** **Date**

# AUTHORIZATION TO USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Social Security #: _____ Phone #: _____

I request and authorize Harris Audiology LLC to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

☐ I consent to Harris Audiology LLC releasing protected health information as detailed below.

☐ I prohibit Harris Audiology LLC from using and disclosing medical information to any person or entity other than required by HIPAA regulations.

My protected health information may be used or disclosed to the following:

_____

_____

For the Purpose of:

_____

_____

If you need assistance in completing the authorization form, please contact Kylie Harris, harrisaudiology@gmail.com.

I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed by Harris Audiology LLC.

I understand that this authorization is in effect until the revocation section of this form is signed or until written notice of revocation is received. I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to **Harris Audiology LLC.**

I authorize Harris Audiology LLC's use and disclosure of my protected health information as set forth above. I understand that this authorization is voluntary and that Harris Audiology LLC cannot condition my treatment, services, etc. on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

_____ _____

**Printed name of patient or personal representative** **Date**

_____ _____

**Printed name of patient or personal representative** **Date**

---

## EXPIRATION/REVOCATION SECTION

Expiration: This authorization will expire on (must choose one):

☐ One year from the date it is signed
☐ Other (insert date or event): _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.

I hereby revoke this authorization.

_____ _____

**Printed name of patient or personal representative** **Date**

_____ _____

**Printed name of patient or personal representative** **Date**

# AUTHORIZATION TO RELEASE AND DISCUSS MEDICAL INFORMATION

I hereby authorize you to use or disclose the specifical information described below, only for the purpose and parties also described below.

Description of the specific information to be released/discussed:

- Appointment Date/Times
- Audiogram Results
- Summary of Medical Records
- Diagnosis
- Care/Treatment Plan
- Other (specify): _____

Patient Name: _____ Date of Birth: _____

**Information to be given to:**

| | | | |
|---|---|---|---|
| Name: | | Name: | |
| Relationship: | | Relationship: | |
| Address: | | Address: | |
| Phone: | | Phone: | |
| Fax: | | Fax: | |

This authorization shall remain in effect from the date signed below and for one year.

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting Kylie Harris, Au.D., CCC-A.
- This authorization is giving Harris Audiology LLC the right to discuss my medical information with the one or more people listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA.
- I may refuse to sign this authorization, and you will not condition treatment or payment on my providing this authorization.

_____ _____

**Printed name of patient or personal representative** **Date**

**Relationship to Patient (if signed by someone other than the patient):** _____