Intake Form: Adult Audiology Services

Last Name	First Name
Street Address	**City, State, Zip**
Primary Phone	**Secondary Phone**
Email Address	Please put a * in front of your preferred method of contact: Phone, email, etc.

Have you been seen in our clinic before?	☐ **Yes**	☐ **No**	**If yes, when?**		
Date of Birth:		**Age**		**Gender**	

What services are you interested in?

Ear Protection *Please fill out Part A below & page 4*		**Diagnosis and Treatment of Hearing Loss** *Please fill out entire form*	
☐	**Custom Earmolds with filters** (Musician ear plugs)	☐	**Hearing Evaluation** (test your hearing and inform you of the findings)
☐	**Custom Earmolds** for sleeping, swimming, etc.	☐	**Hearing Aid Evaluation** (discuss hearing aid options & determine if there is a benefit
☐	**Custom headphone earmolds**	☐	**Audiologic Rehabilitation** (speech reading & other communication strategies)
☐	**Other:**	☐	**Tinnitus Evaluation**

Part A -- Please fill out for Ear Protection Services

History- Have you had, or currently have, any of the following?

	Yes	No	Right	Left		Yes	No	Right	Left
Hearing Loss	☐	☐	☐	☐	Ear Pain	☐	☐	☐	☐
Ear Surgery	☐	☐	☐	☐	Diabetes	☐	☐	☐	☐

If yes, please describe:

Do you take any of the following medications?

Anti-coagulant	☐ Yes	☐ No	Anti-platelet	☐ Yes	☐ No
Thrombolytic	☐ Yes	☐ No	Steroid medications	☐ Yes	☐ No
Chemotherapy medications	☐ Yes	☐ No	Other:	☐ Yes	☐ No

For Ear Protection Services only, please continue to page 6…

Part B-- Please fill out for Diagnosis and Treatment of Hearing Loss

General Health Information

Rate your general Health:	☐ Very Good	☐ Good	☐ Poor	☐ Very Poor

Explain:

Major medical problems:	
Surgeries:	
Physical handicaps:	

Current Medications

Medication:		Reason:	
Medication:		Reason:	
Medication:		Reason:	
Medication:		Reason:	

Hearing History

Do you have hearing loss?	☐ Yes	☐ No	If yes, what was the cause & when were you diagnosed?

Date of your last hearing exam:					
Where did you get your last hearing exam?					
Which is your better ear?	☐ Right	☐ Left			
Do you have blood relatives with hearing loss?	☐ Yes	☐ No	If yes, relationship to you and information about their hearing loss:		
Have you been exposed to very loud noises?	☐ Yes	☐ No	☐ Work	☐ Recreation	☐ Military
Please explain:					
Do you consider your balance to be normal?	☐ Yes	☐ No	If no, please explain:		
Do you have ringing or other noises in your ears?	☐ Yes	☐ No	If yes, please describe:		

Hearing Aid History

Do you currently use hearing aids?	☐ Yes	☐ No
When did you first start wearing hearing aids?		R ☐ L ☐ Both ☐

Make and model:		Year purchased:	
Purchased from:			

Are you satisfied with your hearing aids?	☐ Yes	☐ No	If no, please explain:

If you are not wearing hearing aids, why not?

Assistive Listening Device History (FM systems, alerting devices, etc.)

Do you use a special device to help you hear?	☐ Yes	☐ No	If yes, please describe:

Do you use any special devices to help with the telephone?	☐ Yes	☐ No	If yes, please describe:

Communication History

Have you had any speech-reading, or lip-reading classes?	☐ Yes	☐ No	If yes, please describe

Have you had any training on how to communicate better?	☐ Yes	☐ No	If yes, please describe:

Describe your most challenging communication problems:

Would you like to learn more about speech-reading & communication strategies?	☐ Yes	☐ No

Personal Background

Employer and Position:	Hobbies or spare time activities:

PLEASE BRING ANY HEARING TEST RESULTS & HEARING AIDS TO YOUR APPOINTMENT

Referral Information: How did you hear about our clinic?

☐	**Professional Referral:**	☐	**Website/internet**
	Name:	☐	**Friend**
	From what institution:	☐	**Phone book**
		☐	**Other:**

Payment policies and insurance information

We are not a Medicare provider and we do not bill insurance companies, Medicare or other third-party providers. However, we do accept clients with valid Provider One and Molina Medicaid medical coverage issued by the Department of Social and Health Services (DSHS) for services covered under the plan for speech and hearing services. In the event that DSHS limits or discontinues payment for services, the client becomes responsible for all services received and for services not covered by DSHS.

Provider One or Molina Coverage:		**Please bring your card to your first appointment**	
☐ **No**	☐ **Yes**	**Card Number:**	

We ask you to pay for your services directly by cash, check or credit card at the time of service. A highly regarded aspect of our clinic is our affordable fees for services. As a teaching and research facility, we strive to provide quality services at an affordable cost.

I have read and understand the clinic's payment policy			
Signed:		**Date:**	

Thank you for taking the time to complete this application. It will help us provide you with the best services possible. Upon receipt of your application, your application will be reviewed by the appropriate clinical supervisor to determine what services are needed. You will then be contacted to inform you of your application status. Return this application including the Consent for Care and Clinic Policies Form and Mutual Exchange of Information Form (if we need to request records from other providers). You can email, fax, or mail these documents

UW Speech & Hearing Clinic
4131 - 15th Ave. NE
Seattle, WA 98105
206-616-1185 (Fax)
shclinic@uw.edu (Email)

Consent for Care and Clinic Policies Agreement Form

Please read each section of this form and initial that you have read and understand each policy. Then provide a signature at the end of this form confirming that you have read and understand each section.

CONSENT FOR CARE

I hereby authorize the UW Speech and Hearing Clinic to provide evaluation and treatment services for the above-named client. Additionally, if the faculty, staff, and/or other clinic personnel determine that the client is in need of emergency medical care, the clinic is hereby authorized to obtain the care required, at the expense of the undersigned.

I have read and understand the Consent for Care statement: _____ (initials)

NOTICE OF INFORMATION PRACTICES & PRIVACY POLICY

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it, as well as obtain a copy of the complete Notice of Information Practices and Privacy Policy by calling 206-543-5440.

I have read and understand the Notice of Information Practices & Privacy Policy: _____ (initials)

SUPERVISION OF MINORS POLICY

Under state law, individuals under the age of 18 are considered minors. Parents/guardians are asked not to leave the clinic while a minor under the age of fourteen is in therapy at this clinic. For clients ages 14 to 17, parents/guardians may choose whether or not to accompany the minor to their appointment.
Parents/guardians are solely responsible for determining how their children may safely travel to the UW Speech & Hearing Clinic for their appointment (e.g. bus, drive, walk, bike, etc).

I have read and understand the Supervision of Minors Policy: _____ **(initials)**

MOBILITY TRANSFERS AND RESTROOM POLICY

Clinicians, faculty and staff are not allowed to assist with transfers and toileting. A caregiver or family member of the individual receiving services must be present when the client needs physical assistance with transferring from wheelchair to chair, during ambulation in the clinic, or for bathroom assistance.

I have read and understand the Mobility Transfers and Restroom Procedures Policy: _____ **(initials)**

DISABILITY ACCOMMODATIONS

Both front and back entrances to our clinic are accessible. Both entries have automatic openers, as do our restrooms. Please let us know if you need any accommodations to facilitate receiving services from our clinic.

Accommodations needed:

OBSERVATION AND RECORDING POLICY

The services offered to individuals seen in the Clinic are part of the University's education program. University of Washington faculty, staff, and students receive educational benefits from observing diagnostic, treatment, and other services offered in the University facilities.

Basic Consent: I understand that by accepting services from the Clinic I consent to observation by UW faculty, staff, and students, either live, via recording, or via closed circuit television when I (or the client) receive services.

I understand that I (or the client) may be observed: _____ (**initials)**

Full Consent: In addition, I give my consent to the UW Speech and Hearing Clinic to make audio and/or video recordings of me (or the client) while receiving services to be used for educational purposes, provided the name of the client or other personal identification information is not revealed. These data are only available for educational training purposes. All uses for commercial or research purposes are prohibited unless a separate permission is obtained. Segments of the digital recording with accompanying transcriptions may be presented in the context of academic symposia, university classes, and professional, family or client training activities.

I give my consent to be recorded for educational purposes: _____ (**initials)**

CONSENT TO BE CONTACTED FOR RESEARCH POLICY

UW Speech & Hearing Sciences and the UW Speech & Hearing Clinic are committed to advancing clinical research to improve the lives of people living with communication disorders. Please initial below if you are interested in being contacted by faculty in this department about research studies for which you might be an appropriate participant. You can decline to participate even if you are contacted, you can rescind this offer at any time with no repercussions, your information will not be shared with anyone else on campus or in the community, and you will not be contacted unless you fit the criteria for a specific study.

I give my consent to be contacted about research: _____ (**initials)**

By signing this page, I acknowledge that I have read and agreed to the terms of this Consent for Care and Clinic Policy Agreement Form:

Name of Client: **Date of Birth:**

_____ _____

Signature of Client or Person Responsible for Care **Date of Signature**

If signed by someone other than client, state relationship to client: _____

Consent for Sharing of Digital Records via Email or Cloud Sharing

Please read each section of this form and initial that you have read and understand each policy. Then provide a signature at the end of this form confirming that you have read and understand each section.

CONSENT FOR SHARING OF DIGITAL RECORDS

I hereby authorize the UW Speech and Hearing Clinic to share digital copies of documents, audio recordings, and/or video recordings via email, cloud sharing (such as Dropbox, Google Drive, OneDrive, etc.), or other methods that may be available.

I have read and understand the Consent for Sharing of Digital Records statement: _____ (initials)

NOTICE OF CONFIDENTIALITY RISK

Sharing of digital records via email, cloud sharing (such as Dropbox, Google Drive, OneDrive, etc.), or other methods that may be available may not be secure. The UW Speech and Hearing Clinic cannot guarantee the security and confidentiality of your records that are shared in this manner.

I have read and understand the Notice of Information Practices & Privacy Policy: _____ (initials)

By signing this page, I acknowledge that I have read and agreed to the terms of this Consent for Sharing of Digital Records via Email or Cloud Sharing.

_____ _____

Printed Name of Client **Date of Birth**

_____ _____

Signature of Client or Person Responsible for Care **Date of Signature**

If signed by someone other than client, state relationship to client: _____

UW Speech & Hearing Clinic
4131 15th Ave NE
Seattle, Washington 98105-6246

206.543.5440
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https://sphsc.washington.edu/clinic

SPEECH & HEARING CLINIC
UNIVERSITY of WASHINGTON

RELEASE OF CONFIDENTIAL INFORMATION

Client Name: _____ Date of Birth: _____

The University of Washington Speech & Hearing Clinic is hereby given permission to send summaries of the speech-language and/or hearing evaluations, treatment notes, and/or treatment progress summaries to the individuals listed below. Additionally, I give my permission for the following agencies and/or professionals to release medical/educational information to the University of Washington Speech & Hearing Clinic. I understand that the information will be treated in a confidential manner per this agreement.

Please provide the organization name, ATTN to, address, and fax number for each entry. Check the box to indicate whether we can send information to and/or receive information from each organization below.

Send to ☐ Receive from* ☐

Organization:_____ Fax: _____

ATTN: _____ City: _____ State: _____ Zip Code: _____

Send to ☐ Receive from* ☐

Organization:_____ Fax: _____

ATTN:_____ City: _____ State: _____ Zip Code: _____

Send to ☐ Receive from* ☐

Organization:_____ Fax: _____

ATTN: _____ City: _____ State: _____ Zip Code: _____

Send to ☐ Receive from* ☐

Organization: _____ Fax: _____

ATTN: _____ City: _____ State: _____ Zip Code: _____

*Please provide records for time period of ____ / ____ / ____ through ____ / ____ / ____.

_____ _____

Signature of Client or Person Responsible for Care **Date of Signature**

Consent for release of medical records/confidential information is valid for 365 days from the date of signature.

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