

**UNIVERSITY OF NORTH TEXAS  
SPEECH AND HEARING CENTER**

**Adult Case History—Audiology**

Please fill out this form completely. Use NA for "not applicable," CR for "can't remember," and DK for "don't know."

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Phone: Home\_(\_\_\_\_\_) \_\_\_\_\_

Occupation \_\_\_\_\_ Work\_(\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Referred by \_\_\_\_\_

Chief complaint or reason for referral \_\_\_\_\_

1. Have you had your hearing evaluated previously? yes \_\_\_\_\_ no \_\_\_\_\_  
If so, when and what were the results? \_\_\_\_\_

2. Do you have hearing loss? yes \_\_\_\_\_ no \_\_\_\_\_  
If so, in which ear? right \_\_\_\_\_ left \_\_\_\_\_ both \_\_\_\_\_ When did it begin? \_\_\_\_\_  
Has it become worse? yes \_\_\_\_\_ no \_\_\_\_\_ Does it fluctuate or vary? yes \_\_\_\_\_ no \_\_\_\_\_  
What caused the hearing loss? \_\_\_\_\_

3. Do you hear head noise, ringing, or buzzing in the ears? yes \_\_\_\_\_ no \_\_\_\_\_  
If so, in which ear do you hear it? right \_\_\_\_\_ left \_\_\_\_\_ both \_\_\_\_\_  
Describe how it sounds \_\_\_\_\_

4. Is there a family history of hearing loss? yes \_\_\_\_\_ no \_\_\_\_\_  
If so, who had hearing loss? \_\_\_\_\_  
What was the age it began? \_\_\_\_\_ What caused the hearing loss? \_\_\_\_\_

5. Have you had ear infections? yes \_\_\_\_\_ no \_\_\_\_\_  
If so, in which ear? right \_\_\_\_\_ left \_\_\_\_\_ both \_\_\_\_\_ Have you had drainage? yes \_\_\_\_\_ no \_\_\_\_\_  
What age did they begin? \_\_\_\_\_ How many have you had? \_\_\_\_\_  
When was the last infection? \_\_\_\_\_  
What kind of treatment have you had? \_\_\_\_\_

6. Have you had dizziness or vertigo? yes \_\_\_\_\_ no \_\_\_\_\_  
If so, describe your symptoms \_\_\_\_\_

7. Have you had surgery on your ears? yes \_\_\_\_\_ no \_\_\_\_\_  
If so, which ear? right \_\_\_\_\_ left \_\_\_\_\_ both \_\_\_\_\_  
What type of surgery did you have? \_\_\_\_\_  
When and where was your surgery? \_\_\_\_\_  
Who performed the surgery? \_\_\_\_\_

*Please answer the questions on the reverse side of this form.*

8. Have you had an ear injury? yes\_\_\_\_\_ no\_\_\_\_\_  
If so, describe \_\_\_\_\_
9. Have you had a head injury? yes\_\_\_\_\_ no\_\_\_\_\_  
If so, describe \_\_\_\_\_
10. Check any listed diseases you have had.  
Measles\_\_\_\_\_ mumps\_\_\_\_\_ meningitis\_\_\_\_\_ kidney infection\_\_\_\_\_ malaria\_\_\_\_\_  
Diabetes\_\_\_\_\_ circulatory problems\_\_\_\_\_ other\_\_\_\_\_  
Please list any medications taken for the above: \_\_\_\_\_
11. What medications do you currently take? \_\_\_\_\_  
\_\_\_\_\_
12. Have you had a very high temperature? yes\_\_\_\_\_ no\_\_\_\_\_  
If so, how high was it? \_\_\_\_\_ How long did it last? \_\_\_\_\_
13. Have you had a history of loud noise exposure? yes\_\_\_\_\_ no\_\_\_\_\_  
If so, was it at work? yes\_\_\_\_\_ no\_\_\_\_\_ What type of work? \_\_\_\_\_  
How long were you exposed? \_\_\_\_\_ Did you use ear protection? yes\_\_\_\_\_ no\_\_\_\_\_  
Was it during military service? yes\_\_\_\_\_ no\_\_\_\_\_ What type of noise? \_\_\_\_\_  
How long were you exposed? \_\_\_\_\_ Did you use ear protection? yes\_\_\_\_\_ no\_\_\_\_\_  
Was it during hobbies? yes\_\_\_\_\_ no\_\_\_\_\_ What type of hobbies? \_\_\_\_\_  
How long were you exposed? \_\_\_\_\_ Did you use ear protection? yes\_\_\_\_\_ no\_\_\_\_\_
14. Check your primary means of communication.  
Spoken English\_\_\_\_\_ Spanish\_\_\_\_\_ other language\_\_\_\_\_ sign language\_\_\_\_\_  
Writing\_\_\_\_\_ other\_\_\_\_\_
15. Check the situations where you have difficulty understanding speech.  
In most situations\_\_\_\_\_ in groups\_\_\_\_\_ in noise\_\_\_\_\_ on the telephone\_\_\_\_\_  
All the time\_\_\_\_\_ most of the time \_\_\_\_\_ often\_\_\_\_\_ occasionally\_\_\_\_\_
16. Which ear do you normally use on the phone? right\_\_\_\_\_ left\_\_\_\_\_
17. Have you used a hearing aid previously? yes\_\_\_\_\_ no\_\_\_\_\_  
If so, in which ear? right\_\_\_\_\_ left\_\_\_\_\_ both\_\_\_\_\_ What type of aid? \_\_\_\_\_  
How long did you use it? \_\_\_\_\_ How did it benefit you? \_\_\_\_\_
18. If you have not worn a hearing aid, do you think you might need one? yes\_\_\_\_\_ no\_\_\_\_\_

Additional comments:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship (if other than the patient)

*Please answer the questions on the reverse side of this form.*

# Medical Insurance Information

## Primary Insurance:

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Name of insurance company Insurance Company Street Address City, State, Zip Code

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Insurance company phone number Identification Number Policy or Group number

\_\_\_\_\_  
Policyholder name

Policyholder: Male: \_\_\_\_\_ Female: \_\_\_\_\_  
\_\_\_\_\_  
Policyholder's date of birth

Patient's relationship to policyholder: Self: \_\_\_\_\_ Spouse: \_\_\_\_\_ Child: \_\_\_\_\_ Other: \_\_\_\_\_

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## Secondary Insurance:

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Name of insurance company Insurance Company Street Address City, State, Zip Code

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Insurance company phone number Identification Number Policy or Group number

\_\_\_\_\_  
Policyholder name

Policyholder: Male: \_\_\_\_\_ Female: \_\_\_\_\_  
\_\_\_\_\_  
Policyholder's date of birth

Patient's relationship to policyholder: Self: \_\_\_\_\_ Spouse: \_\_\_\_\_ Child: \_\_\_\_\_ Other: \_\_\_\_\_

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## Tertiary Insurance:

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Name of insurance company Insurance Company Street Address City, State, Zip Code

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Insurance company phone number Identification Number Policy or Group number

\_\_\_\_\_  
Policyholder name

Policyholder: Male: \_\_\_\_\_ Female: \_\_\_\_\_  
\_\_\_\_\_  
Policyholder's date of birth

Patient's relationship to policyholder: Self: \_\_\_\_\_ Spouse: \_\_\_\_\_ Child: \_\_\_\_\_ Other: \_\_\_\_\_

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## Billing Information Insurance Release Form

### Patient Information:

|                   |               |  |
|-------------------|---------------|--|
| /                 | /             |  |
| Last name         | First name    | Middle   |
| /                 | /             | /  |
| Street Address    | Apt/Lot #     | City   |
|                   |               |  |
| State             | Zip Code      | Home Phone #   |
| /                 |               |  |
| Social Security # | Date of Birth | Male <input type="checkbox"/> Female <input type="checkbox"/>                  |
|                   |               | Student: Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> |
| Single            | Married       | Divorced   |
|                   |               |  |
| Separated         | Widowed       | Employed   |
|                   |               | Retired  |
| /                 | ( )           |  |
| Physician         | City          | Phone number   |

### Responsible Party:

|  |                         |               |
|--|-------------------------|---------------|
| /  | /                       |               |
| Full Name                                    | Social Security number  | Date of Birth |
| /  | /                       | /             |
| Street Address                               | Apt/Lot #               | City          |
|  |                         |               |
| State  | Zip Code                | Home Phone #  |
| /  |                         |               |
| Employer                                     | Position                |               |
| /  | /                       | /             |
| Employment street Address                    | Apt/Lot #               | City          |
|  |                         |               |
| State  | Zip Code                | Work Phone #  |
| /  | /                       |               |
| Spouse's full name                           | Social Security number  | Date of birth |
| /  | /                       | /             |
| Street Address                               | Apt/Lot #               | City          |
|  |                         |               |
| State  | Zip Code                | Home Phone #  |
| /  |                         |               |
| Employer                                     | Position                |               |
| /  | /                       | /             |
| Employment street Address                    | Apt/Lot #               | City          |
|  |                         |               |
| State  | Zip Code                | Work Phone #  |
| /  | /                       |               |
| Nearest relative or friend/Emergency contact | Relationship to patient | Phone number  |

### Private Insurance and Medicare/Medicaid Authorization

I authorize payment of medical/Medicare/Medicaid benefits to University of North Texas Speech and Hearing Center for any services furnished to me by the licensed professionals in the clinic. I also authorize you to release to my insurance company or Medicare/Medicaid Administrator any information concerning my health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Date \_\_\_\_\_ Signature \_\_\_\_\_

I understand that I am responsible for payment of all charges incurred on behalf of myself and my family regardless of insurance benefits.

Date \_\_\_\_\_ Responsible Party \_\_\_\_\_

**University of North Texas  
Speech and Hearing Center**

**Authorization**

**Client Name:** \_\_\_\_\_

The University of North Texas Speech and Hearing Center is a training facility designed to provide speech-language pathology and audiology student clinicians with clinical experience. Student clinicians are involved in all aspects of client service delivery. All clinical services are provided under the guidance/supervision of clinical supervisors who hold current state licensure and national certification in Speech-Language Pathology or Audiology. Additionally, student observers may be assigned to observe evaluation/treatment sessions conducted in the center. At times, videotapes of evaluation/therapy sessions are made to assist student clinicians/supervisors in evaluating and planning therapy activities. These videotapes are viewed only by students/clinicians of the Center involved in the case.

\_\_\_\_\_ **I hereby authorize the University of North Texas Speech and Hearing Center to render Speech-Language Pathology/Audiology services to me.**

\_\_\_\_\_ **I hereby authorize students of the Department of Speech and Hearing Sciences to observe evaluation/treatment sessions.**

\_\_\_\_\_ **I hereby authorize videotaping of sessions for use by the student/supervisor assigned to me.**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**University of North Texas  
Speech and Hearing Center**

**Authorization to Release  
Protected Health Information**

I hereby authorize the University of North Texas Speech and Hearing Center to release my protected health information to:

\_\_\_\_\_  
Agency/Individual Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

For the purpose of:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I authorize release of the following:

\_\_\_\_\_  
\_\_\_\_\_

I understand that I may revoke this authorization by submitting a written request to the Center. Such a revocation does not apply to releases prior to the date of the request.

\_\_\_\_\_  
Client or Legal Guardian

\_\_\_\_\_  
Date

For Internal Purposes  
Only:

**University of North Texas  
Speech and Hearing Center**

**Information Regarding Protected Health Information**

I have read the Notice of Health Information Practices provided by the University of North Texas Speech and Hearing Center. I understand how the Center will utilize my protected health information (PHI) and my rights regarding my protected health information.

\_\_\_\_\_  
Client or Parent/Guardian

\_\_\_\_\_  
Date

# University of North Texas Speech and Hearing Center

## Notice of Health Information Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### Introduction

The UNT Speech and Hearing Center is committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

### Understanding Your Health Record/Information

Each time you visit the UNT Speech and Hearing Center, a record of your visit is made. Typically, this record contains documentation of treatment you received and recommendations for future treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the other health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided

### How Your Protected Health Information (PHI) is Used or Disclosed

The following information describes how we may use your PHI without your written consent. Your PHI will be used by the UNT Speech and Hearing Center for treatment, payment, or healthcare operations (TPO). Some specific examples include:

Treatment – Your PHI may be shared with other Health Care professionals in order to provide you the best care. These Health Care professionals may be other clinicians within the UNT Speech and Hearing Center or other providers outside of the Center who are involved in your treatment.

Payment – Your PHI may be shared with billing personnel in order to assure that you are properly charged for services provided. PHI may also be shared with your medical insurance plan administrators to assure payment of a claim.

Health Care Operations – Your PHI may be shared with the UNT Speech and Hearing Center personnel to schedule appointments, order hearing aides, and for quality assurance/improvement efforts. Your PHI may be disclosed to others outside the Center as required by state or federal laws.

The Center may also disclose PHI:

- In order to contact you regarding appointments
- For activities related to supervision of student clinicians involved in your care
- To you, the patient, or if the patient is a minor, to the legal guardian
- To others involved in your care – such as family members
- For law enforcement purposes
- To correctional institutions
- For national security or intelligence
- For fund raising activities for the Speech and Hearing Center, or for UNT

### **Release of Protected Health Information (PHI)**

Except for the situations described above, you must sign an authorization to release your PHI. This authorization will specify who the information will be released to and for what purpose. The Speech and Hearing Center will maintain records of authorized release of your PHI. You may request an accounting of those releases in writing, and you may receive one copy of the accounting detailing all release over the past 12 month period (subsequent to April 14, 2003) free of charge. You may also request specific restrictions for release of your PHI although the center is not required to agree to all requested restrictions. You may revoke an authorization by submitting a written request to the center; however, such a revocation is only valid from the date of the written request and does not include releases prior to that date.

### **Your Rights to Access/Amend Your PHI**

You have the right to inspect and copy your PHI. Requests for inspection must be submitted to the Center in writing, and the Center must respond within 15 days or request a 30-day extension with cause for extension stated. Request to change or amend PHI must be made in writing. Such requests may be denied by the Center.

### **Responsibilities of the Speech and Hearing Center Regarding Your PHI**

The Speech and Hearing Center is required to:

- Maintain the privacy of your health information
- Provide you with this notice of our legal duties and privacy practices regarding your health information
- Allow you access to your health information
- Notify you if we are unable to agree to a restriction regarding release of your information

The Speech and Hearing Center is required by law to provide public notice that assures privacy of PHI is maintained. The Center is required to provide clients with notice of the Center's privacy practices for PHI. The Center may make changes to the privacy practices; however, those changes must be described in an updated Privacy Notice before changes are implemented. The updated Privacy Notice will be available to patients upon request.

### **Your Rights to Report a Complaint or Problem**

You have the right to report a complaint if you believe your privacy rights have been violated. The complaint should be submitted in writing and should specify how the privacy policies were violated. The complaint must be filed within 180 days of the act or omission. The complainant will not be subject to any retaliation for filing a complaint.

To obtain further information on the UNT Speech and Hearing Center policies regarding Protected Health Information

Or

To file a complaint regarding Protected Health Information contact:

Kathy Thomas  
Director, Speech and Hearing Center  
PO Box 305010  
Denton, TX 76203-5010  
940-369-7339  
[kathyt@unt.edu](mailto:kathyt@unt.edu)

*The UNT Speech and Hearing Center welcomes the opportunity to serve a diverse clientele. We do not discriminate with regard to gender, sexual orientation, age, race, creed, national origin or, disability.*