_____
CCCD#

CALLIER CENTER
PATIENT INFORMATION SHEET

Today's Date _____ Preferred Clinic Location: ☐ Callier Dallas ☐ Callier Richardson

☐ **Check here if patient is a UT Dallas employee, student, or a family member of an employee or student.**

PATIENT INFORMATION

Patient Last Name		**Patient First Name**	**Middle Initial**
Patient Date of Birth	**Preferred Name *Optional***	**Primary Care or Referring Provider**	
Home Address	**Apt #**	**1. Home Phone**	
City / **State**	**Zip Code**	**2. Mobile Phone**	
County	**Translator Required** ☐ YES / **Sign Language** ☐ YES	**Preferred Language**	
Email Address (Please print)		**Gender** ☐ Male ☐ Female	
Ethnicity ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Decline to Specify		**Gender Identity** *(optional)* ☐ Male ☐ Female ☐ Other ☐ Transgender _____ ☐ Decline to Answer	
Race ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Decline to Specify ☐ Other			
Marital Status ☐ Divorced ☐ Married ☐ Single ☐ Other	**Driver's License Number**	**Driver's License State**	

EMERGENCY CONTACT INFORMATION

Emergency Contact Name (1)	**Emergency Contact Phone Number (1)**	**Relationship to Patient (1)**
Emergency Contact Name (2)	**Emergency Contact Phone Number (2)**	**Relationship to Patient (2)**

RESPONSIBLE PARTY INFORMATION ☐ Check if patient is responsible party

The parent or guardian of a minor patient (under 18 years) will be listed as the guarantor.

Last Name			First Name	
Date of Birth	Gender		Mobile Phone	Alternate Phone
Responsible Party Address ☐ *Check if same as patient*				
City/State/Zip			Relationship to Patient	

Please tell us how you heard about Callier Center: ☐ Primary Care Provider ☐ ENT ☐ Internet ☐ Social Media ☐ Friend/Family ☐ Other _____	**Is there someone we can thank for the referral.** _____

CALLIER CENTER
FOR COMMUNICATION DISORDERS

THE UNIVERSITY OF TEXAS AT DALLAS

Pediatric Hearing & Balance Case History

CCCD#_____ Today's Date_____

PATIENT INFORMATION

Child's name_____ Date of birth_____ Age_____

Birth sex ☐ Female ☐ Male Who referred you to Callier?_____

Form completed by_____ Relationship to patient_____

What information do you hope to gain from today's visit?_____

_____

FAMILY INFORMATION

Who has legal custody of the child? ☐ Parents (both) ☐Mother ☐ Father ☐ Other_____

List guardians who can make healthcare decisions for patient:

1. Name_____ Relationship _____ Custodial Guardian? ☐Yes ☐No
   Education _____ Type of Work_____ Age_____
   Phone (preferred?) ☐H_____ W☐_____ Cell☐_____
2. Name_____ Relationship_____ Custodial Guardian? ☐Yes ☐ No
   Education _____ Type of Work_____ Age_____
   Phone (preferred?) ☐H_____ W☐_____ Cell☐_____

Language(s) used in the home ☐English ☐Spanish ☐Sign Language ☐ Other_____

MAIN CONCERNS

☐Hearing loss	☐Speech pronunciation	☐Language delay	☐Nonverbal
☐Hearing aid issues	☐Cochlear implant issues	☐Behavior	☐Difficulty with School
☐Tinnitus/Ringing in ears	☐Dizziness/Imbalance	☐Sound sensitivity	☐Repeated ear infections

☐Other_____

When did the problem(s) begin?_____

What do you think caused the problem(s)?_____

What have you already tried to help with problem(s)?_____

DEVELOPMENTAL HISTORY

Describe any concerns you have for your child's current development or behavior_____

_____

Has the child ever experienced difficulty or delay in any of the following areas?

☐Motor (sitting, walking, crawling, self-feeding) ☐Cognitive (problem solving, learning, memory)
☐Communication (understanding & using speech/language) ☐Social/Emotional (behavior & relating to others)

PREGNANCY & BIRTH HISTORY

Is this child yours by ☐birth ☐adoption ☐stepchild ☐foster ☐other_____

Please list any medical problems during pregnancy ☐none ☐specify_____

Delivery by ☐vaginal delivery ☐Caesarian Length of pregnancy in weeks _____ Birth weight _____

Please check any of the following medical problems in the first 3 months of life:

☐NICU stay (indicate length of stay) _____ ☐Difficulty breathing
☐Treated with antibiotics (indicate type)_____ ☐Elevated bilirubin (jaundice)
☐Use of mechanical ventilation ☐Blood transfusion
☐Congenital malformations of the head, neck, or ears (please describe)_____
☐Diagnosis of medical condition (syndrome, heart condition, etc)_____

HEARING HISTORY

Was a newborn hearing screening completed? ☐Yes – passed ☐Yes- failed ☐No ☐Do not know

Hospital/Birthing Center_____ How many times was the screening completed?_____

Does the patient have a diagnosed hearing loss? ☐No ☐Yes – bilateral ☐Yes – unilateral Age at diagnosis_____

Last hearing screening/test date_____ Results_____

Has an MRI of the inner ear been completed? ☐No ☐ Yes Results_____

Does the child use a hearing device? ☐No ☐Yes Type Age fit with device

MEDICAL HISTORY

Please check any conditions that apply to the child:

☐Asthma	☐Ear infections	☐Kidney/bladder disease	☐Sleep problems
☐Anxiety/Depression	☐Ear injury	☐Measles	☐Stroke
☐Cancer	☐Frequent falls	☐Meningitis	☐Swallowing problems
☐COVID19	☐Head injury/Concussion	☐Ringing in ears	☐Syndrome (specify below)
☐Cyclical vomiting	☐Hearing problems	☐Seizures	☐Tubes in ears
☐Cytomegalovirus (CMV)	☐High fever	☐Sensitivity to sounds	☐Vision problems
☐Diabetes	☐HIV positive	☐Severe headaches	☐Muscle weakness

Other problem(s) not listed or explanation of above_____

Did the patient's hearing, speech-language, or behavior change after an illness or accident?_____

List current medications_____

EDUCATION AND THERAPIES

Child's school or daycare _____ Grade in school_____

Does your child have an IFSP, IEP, or 504 plan in place for special education or accommodations? ☐No ☐Yes
Indicate current therapies ☐ Speech-Language ☐ Feeding ☐Occupational ☐Physical ☐ABA ☐Mental health
☐Other_____

CCCD#

CALLIER CENTER
FOR COMMUNICATION DISORDERS

AUTHORIZATION TO RELEASE RECORDS

Please complete this form in its entirety to have information disclosed from UT Dallas/Callier Center to another provider or requestor.
UT Dallas/Callier Center will not condition treatment, payment, enrollment or eligibility for benefits based on the completion of this form.

PATIENT NAME	DOB	DATE	
STREET ADDRESS	CITY	ST	ZIP
HOME PHONE	CELL PHONE		

I hereby authorize the UT Dallas/Callier Center to use and/or disclose my Protected Health Information (PHI).

I UNDERSTAND THE INFORMATION REQUESTED WILL BE RELEASED TO:

☐ **PHYSICIAN/PRIMARY CARE:** _____

CONTACT INFORMATION: _____

☐ **PHYSICIAN/ENT:** _____

CONTACT INFORMATION: _____

☐ **CURRENT SPEECH-LANGUAGE PATHOLOGIST:** _____

CONTACT INFORMATION: _____

☐ **Department Of State Health Services (DSHS)/Texas Early Hearing Detection and Intervention Program (TEHDI)**

☐ **Regional Day School Program for The Deaf (RDSPD):** _____

☐ **Educational Resource Center on Deafness (ERCOD)/Texas School for The Deaf (TSD)**

☐ **Department of Assistive and Rehabilitative Services (DARS)/Early Childhood Intervention (ECI)**

☐ **EARLY INTERVENTION SPECIALIST:** _____

☐ **PARENT SUPPORT GROUP: Texas Hands and Voices/Guide by Your Side**

☐ **LOCAL SCHOOL SYSTEM (ISD):** _____

ADDITIONAL RECIPIENTS

NAME OF PERSON(S) OR ORGANIZATION(S)		RELATIONSHIP TO PATIENT	
ADDRESS	CITY	ST	ZIP
TELEPHONE	FAX		

NAME OF PERSON(S) OR ORGANIZATION(S)		RELATIONSHIP TO PATIENT	
ADDRESS	CITY	ST	ZIP
TELEPHONE	FAX		

INFORMATION TO BE RELEASED (check all that apply and include time period or date of service):

☐ Audiology records _____
☐ Otology records _____
☐ Tinnitus records _____
☐ Speech-Language Pathology records _____
☐ Telephone consultation _____
☐ Other _____

I UNDERSTAND THAT THE INFORMATION IS TO BE RELEASED FOR THE FOLLOWING PURPOSE (check all that apply):

☐ Personal
☐ Meet Insurance/Third Party Payor Requirements
☐ Determine appropriate interventions/services
☐ SSI/Insurance Eligibility
☐ Legal proceedings
☐ Guide diagnosis
☐ Program placement
☐ Other _____

CCCD#

CALLIER CENTER
FOR COMMUNICATION DISORDERS

PATIENT ACKNOWLEDGEMENT

- I understand that the records used and disclosed pursuant to this authorization may include information relating to: Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection; history of drug or alcohol abuse; mental or behavioral health or psychiatric care; and/or other sensitive information.
- I understand that to the extent any recipient of this information, as identified above, is not a "covered entity" under the Federal or Texas privacy laws, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the recipient, and therefore, may be subject to re-disclosure by the recipient.
- I understand that I may revoke this authorization in writing at any time, however, I also understand that such a revocation will not have any effect on any information already used or disclosed by the UT Dallas/Callier Center before receiving my written notice of revocation.
- Unless otherwise revoked, I understand that the date or event upon which this authorization expires is **365 days** from the date of signature.
- A copy of this release will have the same force as the original.
- If I am providing authorization for marketing purposes, I understand that UT Dallas/Callier Center may receive remuneration from a properly authorized business associate as a result of using or disclosing the patient's PHI.
- I may inspect and receive a copy of the information to be used and disclosed pursuant to this Authorization form.
  (Texas law establishes nominal fees for copy charges of medical records)

SIGNATURE OF PATIENT OR SURROGATE DECISION MAKER

DATE

PRINTED NAME OF PATIENT

PRINTED NAME OF SURROGATE DECISION MAKER *(If applicable)*

CCCD#

CALLIER CENTER
FOR COMMUNICATION DISORDERS

Patient Communication Preferences

Please read carefully. The purpose of this document is to protect your privacy.

To protect your privacy and comply with HIPAA (Health Insurance Portability and Accountability Act) regulations, Callier Center wants you to know all the ways we might communicate with you and ensure you understand your right to request communications restrictions. We will say "yes" to all reasonable requests to restrict communication but may still use your information to help improve your care, run our practice, or contact you when necessary. Please see our Notice of Privacy Practices for more information at calliercenter.utdallas.edu.

As a patient of Callier Center, you:

- have access to a secure online patient portal and will be notified by email when you have a new visit summary, document, or message from your provider.
- will be sent appointment reminders via text message.
- may receive voicemail with appointment instructions or for Callier to run our healthcare operations.

You may opt out of any of these communications by selecting the options below.

Secure Access to my Electronic Health Record and Provider Messaging via the Patient Portal

_____ Check here if you do **NOT** want access to your patient portal with secure provider messaging and immediate access to health records and patient documents.

Patient Appointment Reminders via Text Message

Text Messaging is required to receive appointment reminders. Patients may opt-out anytime by responding "stop" to an appointment reminder or,

_____ Check here if you do **NOT** want appointment reminders via text message.

Communication via the Telephone

Detailed messages may be left on my voicemail at this phone number_____

_____ Check here if you do **NOT** want detailed voicemail messages left on your phone. We may still leave a voicemail without patient information to help run our operations.

Patient Name (please print)	Patient Date of Birth
Patient Signature	Date
Parent (child under 18 years) or Guardian Name (please print)	Parent or Guardian Signature

CCCD#

CALLIER CENTER
FOR COMMUNICATION DISORDERS

IMPORTANT NOTICE

Fee, Collection & Appointment Policy

Thank you for choosing **UT Dallas Callier Center**! We are committed to providing you with the best possible care.

FEES

I understand that:

- There is a **$25 service charge** for any check returned by my bank and, once notified, patients will have 10 days to make full payment by cash, credit card, cashier's check or money order
  Failure to comply will result in refusal by the Center to accept future personal checks
- Missed or canceled appointments with less than 24 hours' notice will be subject to a **$50 fee**
  Insurance does not pay for canceled appointment fees
- If patients require additional provider consultation by phone or email lasting over 10 minutes, and outside of a scheduled appointment time, patients will be billed at a rate of **$25 per 10-minute increments**.
  You will be informed when such charges apply
- Patients arriving late may have to be rescheduled and are subject to the **late cancelation fee**

COLLECTION POLICY

I understand that:

- Payment for all services is required **at the time of service**
- Patients are responsible for payment of outstanding claims **over 90 days old**
  If insurance denies payment, you will be required to pay the full balance of your account.
- **Past due** accounts will be referred to a collection agency, and services will be immediately terminated

APPOINTMENT POLICY

I understand that:

- Patients will **not** be seen until all required paperwork is completed
- New patients should arrive **20 minutes before** their scheduled appointment to complete necessary paperwork
- If I have been referred to the Center by an agency, school, or other third party that has agreed to pay for my services, a written referral is required prior to or at the time of my appointment; **otherwise, I am responsible for payment of services.**
- The Center will file insurance claims with commercial insurance companies and Medicaid carriers we are contracted with for services. Some insurance companies require a doctor's referral and preauthorization which does not guarantee payment.
  We strongly recommend that you contact your insurance carrier to verify your personal benefits.
- When possible, we recommend case history paperwork be returned five days prior to the appointment to help your provider plan for your evaluation and request any additional information in advance.

PATIENT ACKNOWLEDGEMENT

I have read and understand the Fee, Collection and Appointment Policy of the UT Dallas Callier Center.

SIGNATURE OF PATIENT OR SURROGATE DECISION MAKER

DATE

PRINTED NAME OF PATIENT

DATE OF BIRTH (PATIENT)

PRINTED NAME OF SURROGATE DECISION MAKER *(If applicable)*

CCCD#

CALLIER CENTER
FOR COMMUNICATION DISORDERS

PLEASE READ CAREFULLY

AUTHORIZATION FORM

Initial each section and sign at the bottom of this form to authorize Callier for the following:

Benefit Release Information: I authorize **Callier Center for Communication Disorders** to release any information necessary to my insurance carrier and/or their agents in order to determine benefits payable for related services. I authorize the payment of medical benefits for these services to be paid directly to **Callier Center for Communication** Disorders. I authorize the release of all clinical information to my referring physician and primary care physician so that he or she can be updated on my condition and the care I receive here.

Initials: _____

Authorization of Treatment: I authorize **Callier Center for Communication Disorders** to provide diagnosis and/or treatment to myself or to _____ (my legal dependent). I understand I have the right to refuse medical services at any time. I further understand no guarantees have been made by any representative of **Callier Center for Communication Disorders** as to the outcome of this service.

Initials: _____

Covered Health Care Operations: I understand that as part of the Center's health care operations, The University of Dallas Callier Center for Communication Disorders provides training in which students and trainees learn under supervision to practice or improve their skills as health care providers. (45 CFR § 164.501)

Initials: _____

PRINTED NAME OF PATIENT

PATIENT DATE OF BIRTH

PRINTED NAME OF SURROGATE DECISION MAKER *(If applicable)*

RELATIONSHIP

SIGNATURE OF PATIENT OR SURROGATE DECISION MAKER

DATE

Optional and intended for families whose children are transported by others:

Authorization for Transportation: I authorize the following person(s) permission to transport my child to and from Callier for patient services.

NAME OF AUTHORIZED PERSON

DRIVERS LICENSE INFORMATION (STATE AND #)

NAME OF AUTHORIZED PERSON

DRIVERS LICENSE INFORMATION (STATE AND #)

I authorize UT Dallas Callier Center employees to discuss services with persons providing transportation.

Initials: _____

CCCD#

CALLIER CENTER
FOR COMMUNICATION DISORDERS

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT

I have had the opportunity to receive and/or review a copy of the Callier Center's Notice of Privacy Practices - located on the Callier Center website at **https://calliercenter.utdallas.edu/** to learn how patient confidential information will be used, disclosed, and protected. A printed copy may be requested at any Callier Center location.

PRINTED NAME OF PATIENT

PATIENT DATE OF BIRTH

PRINTED NAME GUARDIAN *(If applicable)*

RELATIONSHIP

SIGNATURE OF PATIENT OR GUARDIAN

DATE

FOR OFFICE USE ONLY

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

____ Individual Refused to Sign

____ Communication Barrier

____ Care Provided was Emergent

____ Other_____

EMPLOYEE

DATE

EMPLOYEE SIGNATURE

CALLIER CENTER
FOR COMMUNICATION DISORDERS

THE UNIVERSITY OF TEXAS AT DALLAS

Patient Name: _____ DOB: _____ CCCD#: _____

Email: _____ Phone number: _____

CALLIER CLINICAL RESEARCH CENTER
CALLIER CENTER RESEARCH PARTICIPATION AND RESEARCH REGISTRY

The mission of the Callier Center for Communication Disorders is "to transform the lives of those with communication disorders by providing outstanding, leading-edge clinical services; conducting meaningful and innovative basic and applied research into new treatments and technologies; and training the next generation of caring clinical providers and scientists." As a top clinical, research, and training center, individuals entering the Callier Center clinical programs, child development center, Center for Children and Families, and research laboratories may be invited to participate in research studies.

If contacted, individuals can choose to participate or not participate in any research study. Their services will not be affected whether they do or do not participate. Individuals will be provided with a flyer describing the Callier Clinical Research Center (CCRC), the CCRC Participant Registry, and their Rights as Human Research Participants.

You may also choose to be entered into the CCRC Participant Registry. If so, you will be asked to provide basic information for the CCRC Participant Registry, such as contact information, age, and, if applicable, any speech, language, and/or hearing concerns. A Callier Center researcher, who has a study approved by the Institutional Review Board (IRB), may then contact you to invite you to join a research study. You are not obligated to participate in any study. Choosing not to participate does not affect clinical care, child development services, or any other services you or your family engage in at the Callier Center.

If at any time you would like to be removed from the CCRC Participant Registry or to no longer be contacted for possible study participation, please inform any of your service providers at the Callier Center or the registry team by email: callierresearchregistry@utdallas.edu

Or by telephone: Callier Clinical Research Center, (972) 883-3600

Or by mail: Callier Clinical Research Center, Participant Registry, 811 Synergy Park Boulevard, Richardson, Texas 75080

_____
Print Parent or Guardian's name (if applicable)

_____ _____
Signature of Patient, Parent or Legal Guardian Date

If you <u>DO NOT</u> want to be contacted about research, read below:

Initial here if you **<u>DO NOT</u>** want researchers to contact you for possible study participation. _____

Initial here if you **<u>DO NOT</u>** want to be included in the Callier Clinical Research Center Participant Registry. _____

(August 2021)

Participation in Health Information Exchanges (HIEs)
Patient Exemption Request

Patient Name: _____ DOB: _____ CCCD: _____

Email: _____ Phone Number: _____

Electronic health information exchanges (HIEs) allow the Callier Center to securely share important health information electronically with doctors and other healthcare providers. HIEs support fast, reliable, safe, and cost-effective patient care. The Callier Center participates in the following HIEs:

- **Carequality Interoperability Framework** – Carequality is a HIE integrated into eClinicalWorks, an electronic health record (EHR) application used by the Callier Center and many other healthcare providers. Carequality connects health information networks throughout the United States.
- **CommonWell Health Alliance** – CommonWell is a network of healthcare providers and technology companies working together to make it easier for doctors and patients to access health records.

This Exemption Request will terminate your participation in Carequality and CommonWell. Other healthcare providers will still be able to request your health records directly from the Callier Center for coordination of care. Your records may also be disclosed for treatment, payment or operations covered by law without your written permission. Disclosures will follow the Callier Center's approved release of information procedures.

Questions about this Exemption Request may be directed to HIPAA Privacy Officer, The University of Texas at Dallas Callier Center for Communication Disorders, 2895 Facilities Way, Richardson, Texas 75080, Phone: 972-883-3009, Fax: 972-883-3016.

This Exemption Request is **optional,** and **I do not have to sign it**. Refusing to sign will not affect my treatment or payment for services at the Callier Center.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

_____ _____

Print Parent or Guardian's Name (if applicable) Relationship to Patient