

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 <input type="checkbox"/> YES	Sign Language <input type="checkbox"/> YES	Preferred Language	
Email Address (Please print)			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Ethnicity <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Decline to Specify			Gender Identity (optional) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
Race <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Decline to Specify <input type="checkbox"/> Other			<input type="checkbox"/> Transgender _____ <input type="checkbox"/> Decline to Answer	
Marital Status <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> 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 <input type="checkbox"/> Check if same as patient			
City/State/Zip		Relationship to Patient	

Please tell us how you heard about Callier Center: <input type="checkbox"/> Primary Care Provider <input type="checkbox"/> ENT <input type="checkbox"/> Internet <input type="checkbox"/> Social Media <input type="checkbox"/> Friend/Family <input type="checkbox"/> Other _____	Is there someone we can thank for the referral. _____
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CALLIER CENTER
FOR COMMUNICATION DISORDERS

CALLIER CENTER DALLAS
1966 INWOOD ROAD
DALLAS, TEXAS 75235
972.883.3030

CALLIER CENTER RICHARDSON
2895 FACILITIES WAY
RICHARDSON, TEXAS 75080
972.883.3630

THE UNIVERSITY OF TEXAS AT DALLAS | CALLIERCENTER.UTDALLAS.EDU

AUDIOLOGY CASE HISTORY UPDATE

Date: _____ CCCD# _____

Patient Name: _____ Date of Birth: _____ Age: _____

Person completing this form: _____ Relationship to patient: _____

Have there been any significant changes to your (or patient's) medical history (e.g., surgeries, head/neck trauma, disease or illness, allergies, etc.)?

Have there been any noticeable changes to your (or patient's) hearing in either ear or problems with balance (e.g., increased hearing loss, dizziness, ear pain, ear infections, etc.)?

Do you (or patient) have any new occupational, social, or educational concerns that may be related to changes in your hearing or balance?

Current healthcare provider(s):

Provider Name	Specialty or Primary Care	Telephone	City

Current Medications:

Medication Name	Purpose

(03/2017)

**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 _____





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)*

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



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 cancellation 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#

PLEASE READ CAREFULLY
AUTHORIZATION FORM



CALLIER CENTER
FOR COMMUNICATION DISORDERS

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