Austin Voice Institute

Dara W. Allen, M.S., CCC-SLP

Name: ______________________________ Age: _____________________ Sex ___M ___F

Referring Physician: ____

1.Describe your voice problem, including approximate date of onset:

____

____

____

____

2. Was the onset sudden or slow? ____

3. Did your voice problem coincide with illness, a period of tension, excess pressure, excess talking or extra activity? Briefly describe. __________________________________

____

____

____

4. Briefly describe your personality type, interests, etc. (Perfectionist, sports, etc.)

____

____

____

5. Check which best describes your daily voice use:

___Excessive ___Moderate ___Minimal

6. Do you have to talk above noise? ___No ___Yes

If yes, describe. ____

7. Check with best describes your telephone use:

___Excessive ___Moderate ___Minimal

8. Do you talk in the car a great deal? ___No ___Yes

9. Do you smoke? _____ If yes, how long? _____ and How much per day? _____

10. Have you used marijuana in the past year? ___No ___Yes

11. Do you use alcohol? ___No ___Yes

12. Do you have allergies? ___No ___Yes
If yes, describe. ____

13. Do you have sinus problems? ___No ___Yes

14. Do you get regular exercise? ___No ___Yes
If yes, describe. ____

15. Generally speaking, do you sleep well? ___No ___Yes
Fatigue easily? ___No ___Yes

16. Are you currently under a lot of stress? ___No ___Yes

17. Please list any previous voice problems requiring medical or speech evaluation. ____
____
____

18. Prior speech therapy: ____
____
____

19. Prior surgery in the past ten years: ____
____
____

20. Current medications: ____
____
____

For chronic cough and VCD patients:

21. Please describe an episode:
____
____
____
____

22. Does anything make it better?
____

____

23. Other information:

4425 South Mopac, Suite 403 * Austin, Texas 78735 * (512) 466-5013

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Name:____

Please check any symptoms that apply to your present voice problem.

SENSORY SYMPTOMS

____1. Frequent throat clearing

___Productive ___Non Productive

____2. Coughing

____3. Progressive vocal fatigue

____4. Irritation or pain in the throat or back of the throat

____5. Pressure in the chest

____6. Enlargement of neck muscles when speaking

____7. A feeling of a foreign substance or "lump" in the throat.

____8. Ear irritation, tickling or earache

____9. Repeated sore throats

___10. A soreness or burning sensation in the throat (Circle which one.)

___11. Scratchy or dry throat

___12. A feeling that talking is an effort

___13. A choking feeling

___14. Tension and/or tightness in the throat

___15. Back neck tension

___16. Headache

___17. Feeling of throat tightening when you speak

AUDITORY SYMPTOMS

____1. Persistent hoarseness

____2. Reduced vocal range for speaking and singing

____3. Inability to talk at will and at length

____4. Repeated loss of voice

____5. Laryngitis

____6. Voice breaks

____7. Voice comes and goes during the day

____8. Missed speech sounds

____9. Clearer morning voice

____10. Voice gets better in the afternoon or evening

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Fees, Cancellations, and Insurance

The following information details the cost, cancellation and insurance policy. Please keep this information in your file. These policies were made in order to establish a procedure to reduce costs and to best maximize therapy times.

I. Fees

A. Voice Evaluation	$150.00
B. Voice Therapy	$90.00 (per session)
C. Speech Evaluation	$150.00
D. Speech Therapy	$90.00 (per session)

II. Cancellation

A. A twenty-four (24) hour notice of cancellation is required.
B. You will be charged for that time if we do not receive proper notification. Last minute cancellation creates problems involving scheduling and costs and takes time away from other patients. Previous abuse of cancellation has made it necessary to adhere to this policy.

III. Insurance

A. If your policy requires referral/pre-authorization, it is your responsibility to obtain the initial authorization before the visit. If we have referral/authorization, we accept payment by the insurance company except for your co-payment.

B. If we are not providers for your insurance company, it is your responsibility to collect from your insurance company. Fees are payable at each visit, unless otherwise arranged.

C. If the insurance company does not provide payment, you will be responsible for the full amount.

D. To insure payment to Dara Whitehead Allen, please sign the following statements, so that we have your signature on file.

Please indicate your understanding of the above policies.

_______________________________________, _______________________
Patient's Signature Date

_______________________________________, _______________________
Clinician's Signature Date

Thank you for your cooperation. Please remember that you will be billed for an appointment time that is not cancelled with a 24-hour notice.

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Patient Information & Consent Form

Patient Information
Patient Name____
Address________________________City_____________State_____________Zip___________
Work #________________Home #________________ Cell#_____________________________
Date of Birth _________________Sex M__F__ Social Security #__________________________

Insured Information
Name____
Address____
Work #________________Home #________________ Cell#_____________________________
Date of Birth _________________Sex M__F__ Social Security #__________________________

Insured Employment Information
Employer____
Address_______________________City__________________State________Zip____________

Insurance Information
Primary____
Address____
Phone #______________________Policy #_________________Group #___________________
Secondary____
Address____
Phone #______________________Policy #_________________Group #___________________

Referring Physician/Referral Source____
Referral phone #_________________________Date of Recheck_________________________
Reason for visit____
Is this injury or condition related to work_________________ auto accident________________?
Date of Illness____

Personal Information
Type of Work____________________________ Education/ Schooling_____________________
Single Married Divorced Widowed
If married, spouse's name_________________________# of years________________________
Children Y_____ N_____ Names and Ages_______________________________________

I hereby authorize my insurance company to pay directly to_______________________ medical benefits otherwise payable to me, and I will be responsible to said___________________ for all expenses incidental to treatment rendered not paid under this plan.

Patient Signature____ Date__________________
Guardian (if required)____________________________________ Date__________________

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PRIVACY NOTICE (HIPAA) of AUSTIN VOICE INSTITUTE

Right to Notice: as a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance and Accessibility Act (HIPAA), Austin Voice Institute (Dara Whitehead Allen, Speech/Language Pathologist) may use or disclose your health information for treatment, payment and healthcare operations.

a) **treatment**-We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

b) **payment**-We may use and disclose your health information to obtain payment for services we provide you.

c) **Healthcare operations**-We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluation provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization for uses and disclosures that do not fall under treatment, payment, healthcare operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Emergency Situations-In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will disclose health information that is directly relevant to the person's involvement in your healthcare.

Marketing-We will not use your health information for marketing communications without your written authorization.

Required by Law-We may also use or disclose your health information when we are required to do so by law.

<u>Abuse or Neglect</u>-We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health or safety.

<u>National Security</u>-We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized

federal officials required for lawful intelligence, counterintelligence and other national security activities.

We may disclose health information to provide you with appointment reminders via phone, e-mail or letter.

Your Rights as a Patient: You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or healthcare operations. You have the right to receive confidential communications regarding your protected health information. You have the right to inspect and copy your protected health information. You have the right to amend your protected health information. You have the right to receive an account of disclosures of your protected health information. You have the right to a paper copy of this notice or privacy practices.

Legal requirements: Austin Voice Institute is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are distributed to you, and are available within our office.

Complaints: If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.

Contact information: For further information about Austin Voice Institute's privacy policies, please contact us at (512)466-5013.

I attest that I have been offered/given a copy of this document.

____ __________________________

Signature Date