

ROCHESTER HEARING AND SPEECH CENTER
1000 Elmwood Avenue #400 Rochester, NY 14620 (585) 271-0680
3199 W. Ridge Road Rochester, NY 14626 (585) 723-2140
1170 Ridge Road Webster, NY 14580 (585) 872-8073

SCHOOL AGE QUESTIONNAIRE

Date: _____ Name of Person completing this form: _____

Information about the child: **Please complete as much as possible.**

Client's Name: _____
(Last) (First) (M.I.) (nickname)

Age: _____ Birthdate: _____ Sex: M _____ F _____

STATEMENT OF THE PROBLEM:

1. Please state in your own words any concerns you have about the child's speech and language and/or hearing: _____

2. Family history of speech, hearing or learning problems? (check) _____ Yes _____ No
If yes, please explain: _____

3. Is there a language other than English spoken in the home on a regular basis? (This includes American Sign Language.) If yes, please describe and state how often used.

4. What do you hope can be achieved through this evaluation?

SPEECH AND LANGUAGE INFORMATION:

3. Please check all statements that apply to the child.
- _____ I think the child's speech and language are all right for his/her age.
 - _____ The child does not seem to understand spoken instructions.
 - _____ S/he only understands when others show what is wanted.
 - _____ The child has not yet started to talk.
 - _____ S/he talks a little, but not as much as other children the same age.
 - _____ S/he can't explain what s/he wants very well.
 - _____ S/he is difficult to understand.
 - _____ S/he mispronounces sounds or words.
 - _____ S/he often hesitates, holds on to, or repeats sounds or words.
 - _____ Child's voice is nasal/harsh/too loud.

HEARING:

1. Has your child's hearing been tested? _____ Yes _____ No
If yes, when was the testing done, who did it, and what were the results?
When: _____ Who: _____
Results: _____

2. Does your child's hearing seems better in the : _____ left ear _____ right ear _____ both the same

3. Check all statements which apply to the child's hearing:
____ Has no difficulty hearing
____ Child doesn't always answer when called from another room
____ Doesn't always look to find sounds such as a telephone, siren, doorbell, or voice
____ Child hears a loud voice much better
____ Can hear better if the child watches your face
____ Insists on having the TV turned up loud
____ Child's teacher says that s/he has trouble following verbal directions
____ Child frequently says "Huh?" or "What?"
____ Child wears a hearing aid

BIRTH INFORMATION:

1. Describe mother's general health during pregnancy _____

2. Describe mother's illnesses, accidents, or difficulties during pregnancy: _____

3. Medications/alcohol/drugs used during pregnancy, please describe: _____

4. How long was the pregnancy? _____ Baby's birth weight: _____

5. Did the child/mother experience any of the following during labor and delivery or after delivery? (Check all that apply.)
____ difficult/long labor
____ Caesarean section
____ evidence of birth injury
____ birth defects
____ difficulty breathing
____ intensive care nursery
____ Rh problems
____ seizures
____ jaundice (yellowish skin color)
____ cyanosis (bluish skin color)
____ infection
____ Other _____

How was this taken care of? _____

DEVELOPMENTAL HISTORY:

1. Overall development seems to be:
- somewhat faster than most children. In what areas? _____
 - about the same as most children
 - somewhat slower than most children. In what areas? _____
2. Which of the following describe the child's coordination? Check all that apply:
- Has no difficulty with general coordination
 - Has difficulty getting on/off chairs or vehicle toys
 - Frequently stumbles when walking or jumping
 - Has difficulty maintaining balance when sitting, walking, jumping or bending over (underline area of difficulty)
 - Has trouble catching and throwing a ball
 - Seems clumsier than most children
 - Has difficulty working with small objects such as puzzles
 - Other concerns (please describe) _____

BEHAVIOR

1. The child has problems in these areas: (check all statements that apply)
- Frequent temper tantrums
 - Does not interact easily with others
 - Often fights with other children
 - Unusually high activity level
 - Difficulty concentrating or staying with one activity
 - Impulsive
 - Often breaks or destroys things
 - Easily frustrated
 - Short attention span
 - Other: _____

MEDICAL INFORMATION

GENERAL HEALTH

1. Describe general health of the child: _____
2. What medication(s) is the child presently taking? _____
_____ For how long? _____

3. Has the child had any of the following? (Check all statements that apply)

Check	Age		Check	Age	
___	___	failure to thrive	___	___	chicken pox
___	___	mumps	___	___	high fever
___	___	scarlet fever	___	___	seizures
___	___	measles -10 or 3 days	___	___	frequent colds
___	___	pneumonia	___	___	tonsils removed
___	___	meningitis	___	___	adenoids removed
___	___	head injuries	___	___	operations
___	___	allergies	___	___	Other: _____
___	___	asthma			

Please explain: _____

EARS:

- How many ear infections has the child had? ___ When was the first? _____
Most recent? _____ What type of treatment was given? _____
- Check any problems with the child's ears, past and present:
 ___ fluid present in ears. When? _____
 ___ excessive wax
 ___ drainage from ears
 ___ tubes in ears; when inserted? _____ By which doctor? _____
 ___ other: _____

VISION:

- Are there concerns about the child's sight? _____
- Has vision been tested? _____ Where? _____
When? _____ Results? _____

DENTAL HEALTH:

- Are there concerns about the child's teeth or mouth? _____
Describe: _____
- Dentist's name: _____

EDUCATIONAL INFORMATION:

- Present School: _____ Grade? _____
School District: _____
- Has the child repeated any grades? ___ Yes ___ No Which one(s)? _____
- How well does the child do in school? ___ good ___ average ___ below average ___ poor
- If the child is not doing well in school, please describe: _____

SPECIAL SERVICES

Describe any special testing, treatment or therapy the child has had in the past or is currently receiving. (Examples: speech, psychological, developmental, neurological)

I. Evaluations

A. Previous testing completed:

Facility/Location: _____ Date: _____

Results: _____

B. Previous testing completed:

Facility/Location: _____ Date: _____

Results: _____

II. Therapy

A. Services received/receiving: _____

Facility/Location: _____ Date: _____

Frequency _____

Type of therapy (1:1 or group size) _____

B. Services received/receiving: _____

Facility/Location: _____ Date: _____

Frequency _____

Type of therapy (1:1 or group size) _____

III. Present Classroom Information

Teacher's name: _____

Class size: _____

Class modification: _____

PERSONS LIVING IN HOUSEHOLD:

NAME	AGE	RELATIONSHIP TO CHILD
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		
8. _____		

PLEASE SIGN ATTACHED RELEASE FORM

ROCHESTER HEARING AND SPEECH CENTER

Consent to Use and Disclose Protected Health Information for Evaluation, Treatment, Payment and Health Care Operations

Name: _____
(Please print)

Date of Birth: _____

I understand that my signature on this consent is required in order for me to receive services from Rochester Hearing and Speech Center. In addition, I authorize the use and disclosure of my Protected Health Information (PHI) by Rochester Hearing and Speech Center's staff for purpose of evaluation, treatment, payment and health care operations.

I understand that this information may be used or disclosed by Rochester Hearing and Speech Center to

- * plan my care and treatment;
- * communicate among various health care professionals who are involved in my care or treatment;
- * obtain payment for care provided by Rochester Hearing and Speech Center or for the payment activities of another health care provider or entity;
- * provide information to my health insurance company or plan;
- * assess and review the quality of my care. Further information on uses and disclosures of PHI is included in Rochester Hearing and Speech Center's Notice of Privacy Practices.

As part of RHSC's comprehensive services, we will release the findings of your reports to those professionals involved in your care. Reports will automatically be sent to the physician listed and to referral sources. To send these reports, we must have your authorization to do so. This authorization will be valid through this specific course of treatment.

Please list any other specific individuals/facilities you would like information shared/sent to. (e.g., relatives, day care providers, etc.):

If there are any restrictions, please indicate:

I understand that I may cancel this authorization at any time by submitting a written request and that the release of HIV-related information requires additional authorization.

Payment, excluding that covered by insurance, is due at the time of service. If, for any reason, your insurance refuses to pay us for all or part of the service, you will be billed for the service provided. Payment will be due within 30 days of billing. If payment is not received within 30 days, your account will be forwarded to a collection agent, and further services will not be provided until your account is satisfied.

Parent or Legal Guardian (*Print*)

Date

Signature

Relationship

ROCHESTER HEARING AND SPEECH CENTER

Notice of Privacy Practices

This notice describes how your Protected Health Information may be used and disclosed and how you can access this information. Please review it carefully.

Rochester Hearing and Speech Center uses your Protected Health Information (PHI) for treatment, to obtain payment for our services and for our operational purposes, such as improving the quality of care we provide to you. We are required by law to maintain the privacy of your PHI, provide you with this Notice and abide by its terms which describes our health information privacy practices and those of affiliated health care providers that provide care at our facility. If we make any material changes to this Notice, you will be notified.

With your consent, we may use and disclose your PHI for specific reasons:

- **For Treatment:** Our staff and affiliated health care professionals may review and record information in your record about your treatment and care. We will use and disclose this health information to health care professionals in order to treat and care for you. We may contact you to provide appointment reminders.
- **For Payment:** We will bill your insurance company, you directly, or another person that may be responsible for payment of your account. We may need to contact your health plan to see if they will pay for your visits.
- **For Health Care Operations:** We may use and disclose your PHI to others for our agency's business operations. For example, we may use PHI to evaluate our agency's services, including the performance of our staff, and to educate our staff.

Disclosures for Other Specific Purposes:

We may use and disclose PHI about you, without specific consent for the following:

- **Business Associates:** We may share your PHI with our vendors and agents who help us with obtaining payment or carrying out our business functions.
- **Family and Significant Others Involved in Your Care:** Unless you object, we may disclose your PHI to a family member or significant other who is involved in your care or payment for that care.
- **Disaster Relief:** In the event of an unforeseen disaster, we may disclose your PHI to an organization assisting in disaster relief.
- **Public Health and Safety Activities:** We may disclose your PHI for public health activities including the reporting of disease, injury, vital events and the conduct of public health surveillance, investigation and/or intervention.
- **Health Oversight Activities:** We may disclose your PHI to health oversight agencies to conduct audits, investigations, inspections and licensure actions or other legal proceedings.
- **Reporting Victims of Abuse or Neglect:** We may be required to disclose your PHI if we feel that you have been abused or neglected.
- **Law Enforcement:** We may disclose your PHI for certain law enforcement purposes or other specialized governmental functions.
- **Deceased person information:** We may disclose your PHI to coroners, medical examiners, and funeral directors.
- **Judicial and Administrative Proceedings:** We may disclose your PHI in the course of certain judicial or administrative proceedings.
- **Research:** In general, we will request that you sign a written authorization before using your PHI or disclosing it to others for research purposes. However, we may use or disclose your PHI without your written authorization for research purposes provided that the research has been reviewed and approved by a special Corporate Compliance/HIPAA or Institutional Review Board.
- **To Avert a Serious Threat to Health or Safety:** We may be required to disclose your PHI if, in our opinion, doing so will help avert a serious threat to the public.

- **Military Personnel:** We may disclose your PHI to the appropriate command authorities.
- **Worker's Compensation:** We may use or disclose your PHI to comply with laws relating to workers' compensation or similar programs.
- **National Security and Intelligence Activities: Protective Services:** We may disclose PHI to authorized federal officials who are conducting national security and intelligence activities.
- **As Required by Law:** We will disclose your PHI when requested by the law to do so.
- **Marketing and Fundraising:** We may contact you regarding RHSC's services, to share community news or to participate in fundraising activities. You may request to not receive these communications by notifying the person under Questions/Complaints below.

We will use and disclose your PHI other than as described in this Notice or required by law only with your written Authorization. You may revoke your Authorization to use or disclose PHI in writing, at any time. To revoke your Authorization, contact the Medical Records Department. If you revoke your Authorization, we will no longer use/disclose your PHI for the purposes covered except where we have already relied on the Authorization.

CLIENT RIGHTS:

You have the following rights with respect to your health information. If you wish to exercise any of these rights, you should make your request to the Medical Records Department:

- **Right of Access to Protected Health Information:** You may request access to inspect and copy your PHI maintained in our records, including medical and billing records. Your request must be in writing. We will act on your request within 10 days after we receive it. If we must deny your request, we will send you a written denial. If this happens, you may request a review of the denial. We may charge you a fee for this service.
- **Right to Request Restrictions:** You may ask us to limit our use or disclosures of your PHI. We will abide by your request except as required by law, in emergencies, or when the information is necessary to treat you. Your request must be in writing, describe the information that you want restricted, state if the restriction is to limit our use or disclosure and state to whom the restriction applies.
- **Right to an Accounting of Disclosures:** You may request a list of disclosures that we have made of your PHI over the previous six years. You may not request an accounting for date of service prior to April 14, 2003. Your first request within a 12-month period is free, but we may charge for additional lists within the same 12-month period.
- **Right to Request Amendment:** You may ask us to amend your health information if you believe that it is incorrect or incomplete. Your request must be in writing and must include a reason to support the amendment. We may deny your request and if we do so, will give you a written denial including reasons for the denial and an explanation of your right to submit a written statement disagreeing with the denial.
- **Right to a Paper Copy of This Notice:** You have the right to obtain a paper copy of this Notice by using the contact information. (You may also obtain a copy of this Notice at our website, www.rhsc.org.)
- **Right to Request a Confidential Communications:** We will make every effort to communicate with you in a confidential manner. You have the right to request that we communicate with you concerning personal health matters in a certain manner or at a certain location.

QUESTIONS/COMPLAINTS: Questions or complaints about this Notice of Privacy Practices or how Rochester Hearing and Speech Center handles your health information should be directed to: Rochester Hearing and Speech Center, Attn: Kathleen Gilman, 1000 Elmwood Avenue, #400, Rochester, NY 14620. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to the Secretary of the Department of Health and Human Services.

Effective Date: 4/13/03 (v.1)

Rochester Hearing and Speech Center Clients' Bill of Rights

Clients' rights. Policies and procedures shall be developed and implemented regarding the clients' rights. The operator shall have in effect a written statement of clients' rights which is prominently posted in client care areas and a copy of which is given to the client. Such statement shall include the clients' rights to:

- (a) receive service(s) without regard to age, race, color, sexual orientation, religion, marital status, sex, national origin or sponsor;
- (b) be treated with consideration, respect and dignity including privacy in treatment;
- (c) be informed of the services available at the center;
- (d*) be informed of the provisions for off-hour emergency coverage;*
- (e) be informed of the charges for services, eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care;
- (f) receive an itemized copy of his/her account statement, upon request;
- (g) obtain from his/her health care practitioner, or the health care practitioner's delegate, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the client can be reasonably expected to understand;
- (h) receive from his/her clinician information necessary to give informed consent prior to the start of any non-emergency procedure or treatment or both. An informed consent shall include, as a minimum, the provision of information concerning the specific procedure or treatment or both, the reasonably foreseeable risks involved, and alternatives for care or treatment, if any, as a reasonable clinician under similar circumstances would disclose in a manner permitting the client to make a knowledgeable decision;
- (i) refuse treatment to the extent permitted by law and to be fully informed of the clinical consequences of his/her action;
- (j) refuse to participate in experimental research;
- (k) voice grievances and recommend changes in policies and services to the center's staff, the operator and the New York State Department of Health without fear of reprisal;
- (l) express complaints about the care and services provided and to have the center investigate such complaints. The center is responsible for providing the client or his/her designee with a written response within 30 days if requested by the client indicating the findings of the investigation. The center is also responsible for notifying the client or his/her designee that if the client is not satisfied by the center response, the client may complain to the New York State Department of Health's Office of Health Systems Management;
- (m) privacy and confidentiality of all information and records pertaining to the client's treatment;
- (n) approve or refuse the release or disclosure of the contents of his/her medical record to any health-care practitioner and/or health-care facility except as required by law or third-party payment contract;
- (o) access his/her medical record pursuant to the provisions of section 18 of the Public Health Law, and Subpart 50-3 of this Title;
- (p*) authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors; and*
- (q*) make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the center.*

** Not applicable to RHSC*

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My signature below acknowledges that I have received a copy of Rochester Hearing and Speech Center's Notice of Privacy Practices and the Clients' Bill of Rights.

Client Name (*Print*)

Date

Client Signature

If child:

Parent or Legal Guardian (*Print*)

Date

Signature

Relationship to Client

For Facility Use Only:

Rochester Hearing and Speech Center made a good faith effort to obtain the above referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices.

Staff Member

Date