**Patient Registration Form (ages 0 months - 6 months)** Thank you for choosing Palmetto Audiology and Speech Therapy for your testing and/or treatment. Please fill out the following information to the best of your knowledge. All of these factors are considered while completing a thorough diagnostic evaluation. If further explanation is needed, please feel free to make notes on the reverse side of this sheet.

Childs Legal Name: _____

Childs Preferred Name: _____ Date of Birth: _____

Parent (s) Name (s): _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security # for Responsible Party: _____

Preferred Phone Number for Voice Confirmation Calls: _____

Preferred Phone Number for Text Confirmation: _____

Emergency Contact Name, Relationship and Phone Numbers: _____

Primary Email Address: _____

How did you hear about our office: _____

Primary Care Physician / Physician's Office: _____

*please be prepared to supply all medical insurance cards as well as your photo ID to receptionist upon arrival in our office

*Assignment and release*: I certify I have primary health insurance coverage with _____

And secondary with _____ (and third with _____).

I agree to assign Palmetto Hearing Care Center dba Palmetto Audiology and Speech Therapy directly all insurance benefits. I understand that I am financially responsible for any and all charges, whether or not they are paid by my health insurance. I agree to allow this office to use/disclose healthcare information to my insurance company and their agents for the purpose of obtaining payment for services and for determination of benefits I am eligible for. This consent will end one year from the end of my treatment.

**Signature of Patient or Legal Representative: _____Date: _____**

*HIPAA Notice of Privacy Practice Summary*: Please see the front desk if you require a review of our full copy of our Notice of Privacy Practices. We use health information about you with this authorization to obtain payment for services, for administrative purposes and to evaluate the quality of care you receive. Be aware that we have use your health information without your consent for the following reasons: public health emergency or research purposes, accounting purposes, or emergencies. We provide information when otherwise required by law, such as law enforcement purposes or as requested by the courts. In ANY other circumstances we will ask for your authorization to share any information. If you choose to sign this authorization to disclose information, you have the legal right at any time to revoke our authorization in writing. Your RIGHTS: Although your health record is the property of Palmetto Audiology and Speech Therapy, the information belongs to you. You have the right to: (1) request a restriction on certain uses and disclosures of your information in writing per 45 CFR 164.522 (2) request a copy of the notice of Privacy Practice (3) Inspect a copy of the health record portion of your chart as per 45 CFR 164.524 (4) Amend your health record as per 45 CFR164.528 (5) Request communications of your health information by alternative means or alternative locations (6) Obtain an accounting disclosure of your health information as per 45 CFR 164.528 (7) revoke your authorization or use or disclosure of health information except to the extent that action has already been taken.

Complaints: If you are concerned that we have violated your privacy rights or you disagree with a decision we made about access to your records, you may contact Darin Bish at 843-871-3235. You may also send a written complaint to the US Department of Health and Human Services. By signing below, I acknowledge that I have received the Notice of Privacy Practice Summary. I understand that as listed above, I have the right to request restrictions as to how my health information may be used or disclosed and that The Hearing Shoppe is not required to agree to the restrictions I request in the event of situations outlined above. I also understand that at The Hearing Shoppe, it is standard practice to inform your primary care physician as well as any other referring physicians the outcomes of any and all testing and therapy that is completed in our office. You agree, in order for us to service your account or to collect any amounts you may owe we may contact you by phone at any phone number associated with your account, including wireless numbers. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing service, as applicable. You also authorize and consent to us providing your contact information to any third-party for the purpose of collecting any amounts you may owe.

**Signature of Patient or Legal Representative: _____ Date: _____**

Witness: _____ Date: _____

Please list here anyone who you authorize, in addition to your PCP or referring physician, to receive a report of your finding:

_____ (initial here) _____

Developmental Questionnaire (Ages 0 months - 6 months) Date: _____

Your baby's due date was: _____
Birth weight: _____
Place of birth: _____

Pregnancy/Delivery/Newborn History: (Please check any conditions that occurred with patient's mother during her pregnancy or with the patient as an infant and provide further details if needed – if extra space is needed, please use back of this form).

- Illness_____
- Injury_____
- Bleeding _____
- Anemia_____
- Operations_____
- High Blood Pressure_____
- Drug use in pregnancy_____
- Alcohol use in pregnancy_____
- Birth Defects _____
- Oxygen deprivation _____
- Seizures_____
- Meconium Ingestion _____
- Cardiac Complications_____
- Jaundice in need of Transfusion_____
- IV Antibiotics_____
- Syndromes_____
- Tube Feeding _____
- Hospitalizations_____
- NICU Admission_____
- Other _____

Dear new Moms and Dads:

If your infant is coming in for a hearing test, ***please do your best to have your baby asleep for the testing***. Please feel free to leave your baby asleep in their car seat or stroller, as we prefer to test them as they sleep in their own space (some parents bring in a favorite bouncy seat or portable swing if it seems to be the magical touch to get them asleep). We also allow/encourage a baby to nurse or have a bottle to calm them before we start testing. We allow a full 30-60 minutes for your appointment so please have the courtesy to give us at least 24 hours' notice if you cannot come to your appointment. DHEC does require that a passing test is registered with them and the younger the infant is, the easier the testing is to complete to meet their standards. Please make every attempt to make your appointment. We will evaluate your child's cochlear (hearing) and ABR (brain response) during the visit as well as the function of their eardrum. The testing is completely safe and 100% painless. See you soon and I look forward to meeting you and your baby!

*-Dr. Kristen Bish, AuD.*