REGISTRATION

(PLEASE PRINT)

New York Speech and Hearing, Inc.

Dr. Melissa E. Heche

Doctor of Audiology/Voice & Swallowing Pathologist

271 Madison Ave., Ste. 1405 — New York, NY 10016

Telephone: (212) 260-1414

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Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

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ADULT VOICE CASE HISTORY FORM

Date: _____

Last Name: _____ First Name: _____

Reason for Visit: _____

Referred By: _____ Ref Physician's Tel: _____

Ref Physician's Address: _____

Primary Care Physician: _____ PC Physician's Tel: _____

Physician's Address: _____

Please describe, in your own words, your voice: _____

What motivated you to seek advice or help regarding your voice? _____

HISTORY OF THE PROBLEM

Describe the existing voice problem _____

When did you first notice its presence? _____

What were the circumstances? _____

How long has it been present? _____

Do you know why it is present? _____

If so, explain. _____

Have you been seen by an ear, nose, and throat physician? Yes/No Date Seen: _____

Results/diagnosis: _____

Recommendations: _____

_____

Estimated Severity of the Problem: ___ Mild ___Moderate ___ Severe

What other individuals recognize your problem? _____

How would you describe your voice (check all items that apply):

☐ Voice pitch too high	☐ Voice pitch quivers	☐ Hoarse
☐ Voice pitch too low	☐ Frequent pitch breaks	☐ Monotonous
☐ Voice too loud	☐ Infrequent pitch breaks	☐ Nasal
☐ Voice too soft	☐ Difficulty controlling voice	☐ Breathy
☐ Voice intensity quavers	☐ Harsh	☐ Other _____

Do you think your breathing has anything to do with your voice problem? __ Yes __ No

Have you ever been a mouth breather? _____ If yes, when? _____

How has this voice problem affected you? _____

Variation of the Problem:

List 3 situations in which the voice problem is least troublesome

1. _____
2. _____
3. _____

List 3 situations in which the voice problem is most troublesome

1. _____
2. _____
3. _____

What happens to your voice when you are:

Excited? _____ Angry? _____

Anxious? _____ Depressed? _____

Do you have any pain/tightness in the neck, face, or ears? __ Yes __ No

Describe the pain/tightness: _____

Do you have throat pain in the morning? _____ Evening?_____ After talking for extended periods of time? _____

When is your voice better? ___ Morning ___ Midday ___Evening ___No change during day

How often do you "lose" your voice? _____

Have you ever received any prior speech, voice, or hearing evaluation/therapy?_____ If yes, where/when? _____

Did prior evaluation/therapy relate to the present problem? _____

What was the nature of the evaluation/therapy? _____

How effective has prior therapy been in helping with the problem? _____

FAMILY AND ENVIRONMENTAL INFORMATION

Please list names/ages/relationship of each family member living in the home: _____

_____

Description of vocal/laryngeal use (daily use and/or abuse): _____

	OFTEN	SOMETIMES	NEVER		OFTEN	SOMETIMES	NEVER
Talking in noisy environment				Sneezing			
Excessive speaking				Clearing throat			
Talking on the phone				Singing			
Screaming				Voice impersonations			
Yelling				Cheering			
Coughing				Caffeine Consumption			
Shouting							

Any singing experience? _____ If yes, please describe _____

Occupation: _____

Describe the capacity in which you use your voice during the work day: _____

_____

Are you under stress: _____

Is there a family history of emotional difficulties? _____

Does anyone in the immediate family or among close associates have a similar voice problem? ___If so, who? _____

Are there pets in the home? _____

HEALTH HISTORY

Is there a history of:

- ☐ Allergies
- ☐ Sinus Infection
- ☐ Asthma
- ☐ Broken noise
- ☐ Bronchitis
- ☐ Chronic colds
- ☐ Chronic Laryngitis
- ☐ Chronic Rhinitis
- ☐ Poliomyelitis
- ☐ Rheumatic Fever
- ☐ Retarded sexual development
- ☐ Developmental syphilis
- ☐ Psychological counseling
- ☐ Glandular imbalance
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Whooping Cough
- ☐ Hypertension
- ☐ Drug Use (non medicinal)Numbness
- ☐ Paralysis/Paresis
- ☐ Incoordination of face or tongue muscles
- ☐ Influenza
- ☐ Mouth breathing
- ☐ Pneumonia
- ☐ Physical defect
- ☐ Clef Palate
- ☐ Ear Disease
- ☐ Scarlet Fever
- ☐ Hearing Problem
- ☐ Typhoid Fever
- ☐ Tremor/Twitching
- ☐ Ulcers
- ☐ Visual Problem
- ☐ Hormone theraphy
- ☐ Heart Trouble
- ☐ Other _____

If yes to any above items, explain _____

_____

_____

Do you smoke? ☐ Yes ☐ No Did you smoke? ☐ Yes ☐ No

If you ever smoked, when did you stop? _____

Do you drink? ☐ Yes ☐ No If so, how many drinks per day? _____

Hospitalizations/Surgeries:

Year:	Reason:	Reason for hospitalization / TYPE of surgery
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had a trauma to the head or neck? _____

Have you ever had a neurological examination? _____ If yes, by whom, when, and where? _____

_____

List all prescription and nonprescription medication used over the past year: _____

_____

Additional comments or questions? _____

_____

_____

VOICE HANDICAP INDEX

Name: _____ Date: _____

These are statements that many people have used to describe their voices and the effects of their voices on their lives. Circle the response that indicates how frequently you have the same experience.

0-never 1-almost never 2-sometimes 3-almost always 4-always

Part I-F

My voice makes it difficult for people to hear me.	0	1	2	3	4
People have difficulty understanding me in a noisy room.	0	1	2	3	4
My family has difficulty hearing me when I call them throughout the house.	0	1	2	3	4
I use the phone less often than I would like to.	0	1	2	3	4
I tend to avoid groups of people because of my voice.	0	1	2	3	4
I speak with friends, neighbors, or relatives less often because of my voice.	0	1	2	3	4
People ask me to repeat myself when speaking face-to-face.	0	1	2	3	4
My voice difficulties restrict my personal and social life.	0	1	2	3	4
I feel left out of conversations because of my voice.	0	1	2	3	4
My voice problem causes me to lose income.	0	1	2	3	4

SUBTOTAL _____

Part II-P

I run out of air when I talk.	0	1	2	3	4
The sound of my voice varies throughout the day.	0	1	2	3	4
People ask, "What's wrong with your voice?"	0	1	2	3	4
My voice sounds creaky and dry.	0	1	2	3	4
I feel as though I have to strain to produce voice.	0	1	2	3	4
The clarity of my voice is unpredictable.	0	1	2	3	4
I try to change my voice to sound different.	0	1	2	3	4
I use a great deal of effort to speak.	0	1	2	3	4
My voice is worse in the evening.	0	1	2	3	4
My voice "gives out" on me in the middle of speaking.	0	1	2	3	4

SUBTOTAL _____

Part III-E

I am tense when talking to others because of my voice.	0	1	2	3	4
People seem irritated with my voice.	0	1	2	3	4
I find other people don't understand my voice problem.	0	1	2	3	4
My voice problem upsets me.	0	1	2	3	4
I am less outgoing because of my voice problem.	0	1	2	3	4
My voice makes me feels handicapped.	0	1	2	3	4
I feel annoyed when people ask me to repeat.	0	1	2	3	4
I feel embarrassed when people ask me to repeat.	0	1	2	3	4
My voice makes me feel incompetent.	0	1	2	3	4
I am ashamed of my voice problem.	0	1	2	3	4

SUBTOTAL _____

TOTAL _____

The Voice Handicap Index (VHI): Development and Validation
Barbara H. Jacobson, Alex Johnson, Cynthia Grywalski, Alice Silbergleit, Gary Jaconsen, Michael S. Benninger

American Journal of Speech-Language Pathology, Vol 6(3), 66-70, 1997, The Voice Handicap Index is reprinted with permission from all authors and ASHA. Copyright 1997-2001 American Speech-Language-Hearing Association

The Reflux Symptom Index

Reflux Symptom Index Scale Test: Rate the following items on a scale of 1-5. The composite of these scores should be 10 or below. If it is more than 10, you should consider an evaluation to check for "Silent Gastroesophageal Reflux Disease," or GERD.

The Reflux Symptom Index

Within the past month, how did the following affect you?

0 = No problem
5 = Severe problem

Hoarseness or a problem with your voice?	0	1	2	3	4	5
Clearing your throat?						
Excess throat mucus or postnasal drip?						
Difficulty swallowing food, liquids or pills?						
Coughing after you ate or lie down?						
Breathing difficulties or choking episodes?						
Troublesome or annoying cough?						
Sensations of something sticking in your throat						
or a lump in your throat?						
Heartburn, chest pain, indigestion, or stomach acid						
coming up?						

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New York, NY 10016
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Notice of Privacy Practices Acknowledgment / Patient Authorization Form

I hereby authorize New York Speech and Hearing, Inc. to use or disclose my personal health information for the purposes and parties below.

A healthcare provider for treatment, healthcare clearing houses (billing purposes), individual or group plans that provide or pay for the cost of medical care; such as employee welfare benefit plans, health insurance issuers, other property and casualty carriers and:

_____

_____

The information is being requested for the following purpose(s):

_____

_____

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting the office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and longer protected by HIPPA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is used for research-related treatment, in which case you may refuse to provide that research-related treatment).
- I understand that you will receive compensation from a third party for the use or disclosure of my information.

Patient Name: _____
Patient Signature: _____ **Date**: ___ / ___ / ____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this origination at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how private my information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Name: _____ **Relationship to patient**: _____
Signature: _____ **Date**: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: ___ / ___ / ___ Initials: _____

Reason: _____

PAYMENT POLICY

THIS POLICY APPLIES TO ALL VISITS MADE TO OUR OFFICE AND MUST BE SIGNED BEFORE THE APPOINTMENT.

Professional services rendered are charged to the patient. The patient is responsible for all fees regardless of insurance coverage as confirmation of coverage is not a guaranty of payments.

It is the responsibility of the patient to know the benefits and exclusions of their insurance coverage.

If services are provided through a managed care plan that our office participates in, then the patient is responsible for their co-payment and referral. The patient MUST have their insurance card(s) and, if required, referral at the time of the visit.

Please note that deductibles, out of pocket expenses, co-insurance amounts, and non-covered services include 'patient responsibility,' 'patient payable,' 'customer amount,' 'customer liability,' etc. Services not covered will be billed directly to the patient.

We do not accept assignment for any insurances in which we do not participate. There are no exceptions to this policy. Insurance is a form of reimbursement to you and not a form of payment to us.

MEDICARE PATIENTS – It is your responsibility to obtain a script from your primary care physician requesting a hearing evaluation. This must be in hand at the time of the visit.

METHODS OF PAYMENT – We accept cash, check, Visa, and MasterCard. Returned check fee for any reason is $25.00.

By reading and signing this document, I fully understand my responsibilities described in the above policy. I also realize that non-covered services, co-insurance amounts, and deductibles will be billed directly to me. Co-pays and out-of-pocket expenses are due at the time each service.

_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

_____

PRINT NAME OF PATIENT