



COLLEGE OF FINE ARTS & COMMUNICATION
LAMAR UNIVERSITY
Department of Speech & Hearing Sciences

Audiology and Speech-Language Pathology Adult Patient History Form

Mr./Mrs./Ms./Dr. _____ Date of Birth: _____

Occupation: _____ Referral: _____

What brings you in today? _____

Please provide a brief description of this situation and related events/illnesses. _____

Do you have a family history of hearing loss? _____

Have you had any of the following evaluations at any other clinic in the past?

Speech, Voice, Language Evaluation ☐ YES ☐ NO

Audiological/Hearing Evaluation ☐ YES ☐ NO

Name of clinic:

Name of clinic:

Address:

Address:

Phone number:

Phone number:

Date of evaluation:

Date of evaluation:

Results: _____

Do you have a better ear? R L Do you have hearing aids? Y N Ear aided: R L

Length of use: _____ Ear surgeries/procedures: R L

Allergies: _____

Tobacco User: Yes No **Describe:** _____

Please check if you have ever been diagnosed with or exposed to:

<input type="checkbox"/>	Chemo/Radiation	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Migraines
<input type="checkbox"/>	Chronic ear infections	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Parkinson's Disease
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Dementia	<input type="checkbox"/>	Memory loss	<input type="checkbox"/>	Traumatic Brain Injury
<input type="checkbox"/>	Dysphagia (swallowing disorder)	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	Other:		

Please check all that apply for your visit with us today:

	Hearing loss		Difficulty hearing in noise		Difficulty understanding speech in noise
	Exposure to loud sounds		Buzzing/ringing in ears		Dizziness
	Interested in hearing aids		Feeling of ear fullness		Ear discharge or pain
	Excessive ear wax		Other:		

	Difficulty finding words/names		Difficulty speaking in complete sentences		Stuttering/dysfluency
	Difficulty understanding speech		Difficulty coordinating voice, tongue, lips, etc for speech		Shortness of breath when talking
	Difficulty pronouncing specific sounds:		Drooling		Change in quality of voice
	Difficulty moderating social skills		Change in volume of speech		Change in voice pitch
	Foreign or regional dialect		Other:		

Please describe items checked above. _____

When did you first notice symptom(s)? _____

Please share any additional information you feel is important for today's visit:

Signature

Date

If completed by a third party:

Name of person completing intake form

Relationship

Signature

Date



Name: _____

LIST OF CURRENT MEDICATIONS:

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, albuterol, nitroglycerin).

Medication (Brand and Generic Name)	Dose	How and How Often You Take the Medication	Reason for taking	Date Started	Prescriber

Check here if additional pages of medicine list attached []



Name: _____

Continuation of List of Current Medications

Page ____ of ____

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, albuterol, nitroglycerin).

Medication (Brand and Generic Name)	Dose	How and How Often You Take the Medication	Reason for taking	Date Started	Prescriber



COLLEGE OF FINE ARTS & COMMUNICATION
LAMAR UNIVERSITYTM
Department of Speech & Hearing Sciences

Release of Information

Patient Name: _____ DOB: _____

Guardian: _____ Relationship to Patient: _____

Address: _____ City: _____ ZIP: _____

I hereby authorize and grant Lamar University Speech and Hearing Clinic permission:

1. To release/receive confidential/diagnostic information concerning the above named patient to assist in evaluation and planning his/her treatment management program.
2. To release documentation to primary care physicians and any referring provider in order to maintain continuation of care.
3. To record the voice and image of the above named patient. I understand the material recorded may be used for educational, informational, training, and/or research purposes. However, without personally identifying the patient by name.
4. To use such diagnostic, therapeutic/ management and motivational procedures as the Clinic Director, Supervisors, and Clinicians deem necessary and appropriate.
5. To utilize Graduate Clinicians in the delivery of evaluation and/or treatment programming.
6. To utilize data collected during appointments for research purposes.
7. To contact the patient at all provided contact points including email.

In signing this form, I absolve Lamar University and its Speech and Hearing Staff from any liability in the exercise of its best clinical decision making and judgments.

Signature (Patient or Guardian)

Date

At My Request

I hereby grant permission for a release of information to/from doctors, schools or other agencies as specified below.

Agency: _____ Phone: _____

Address: _____

Signature: _____ **Date:** _____

Agency: _____ Phone: _____

Address: _____

Signature: _____ **Date:** _____

Agency: _____ Phone: _____

Address: _____

Signature: _____ **Date:** _____

Agency: _____ Phone: _____

Address: _____

Signature: _____ **Date:** _____

Patient Intake Form



LAMAR UNIVERSITY
Audiology Clinic

Title:	Mr. Mrs. Ms. Dr.
First Name:	
Middle Initial:	
Last Name:	
Suffix:	
Preferred Name:	
Address 1:	
Address 2:	
City:	
State/Province:	
Zip Code:	
Country:	
Marital Status:	
Employment:	

Insurance: Yes / No

Gender:	
Date of Birth:	
Preferred Language:	
Home Phone:	
Work Phone:	
Cell:	
Other:	
E-mail Address:	
Spouses Name:	
School:	
Clinic:	Speech / Audio

Emergency Contact OR Parent or Guardian(Only if filling out for minor child)

Name:		Relationship to Patient:	
Address 1:		Phone Number:	
Address 2:		Email:	
Zip Code:			

Physician Information

Primary Physician:		Referring Physician:	
Phone Number:		Phone Number:	
City:		City:	

I authorize any holder of medical or other information about me to release any information needed to process this or other claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Patient/Responsible Party Signature

Date:



COLLEGE OF FINE ARTS & COMMUNICATION
LAMAR UNIVERSITY
Department of Speech & Hearing Sciences

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the Lamar University Speech & Hearing Clinic, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In the event that a requested service may not be presumed to be a covered benefit, an Advance Notification of Benefits form (ABN) must be filled out and payment is required at the time of services.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feosor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare, Medicaid and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient Name: _____ Signature: _____ Date: _____

HIPAA

By signing below I acknowledge that I have been provided Lamar University Speech & Hearing Clinic's Notice of Privacy Practices and have therefore been advised about how certain health information about me may be used and disclosed by our clinic, and how I may obtain access to and control of this information:

Patient Name: _____ Signature: _____ Date: _____

LAMAR UNIVERSITY

Physical Plant



1. Mamie McFaddin Ward
2. Dishman Art Museum
3. Art
4. University Theatre/KVLU
5. James M. "Jimmy" Simmons Music Building and Rothwell Recital Hall
6. Health & Human Performance Complex A&B
7. Hayes Biology
8. Science Auditorium
9. Theater Arts
10. Social & Behavioral Sciences
11. Geology
12. Archer Building
13. Galloway Business
14. Montagne Center
15. Provost Umphrey Stadium, W.S. "Bud" Leonard Field and Dauphin Athletic Complex
16. Chemistry
17. Ty Terrell Track
18. Sheila Umphrey Recreational Sports Center and McDonald Gym
19. Setzer Student Center
20. Carl Parker Building Undergraduate Advising Center
21. Setzer Center Bookstore
22. Lucas Engineering
23. Wimberly (Admissions)
24. Visitors Parking
25. Plummer (Administration)
26. Communication Building
27. Post Office/Police
28. Family & Consumer Sciences
29. Mary & John Gray Library
30. Engineering Research Center
31. Cherry Engineering
32. Newman Catholic Center
33. Church of Christ Student Center
34. Honors Program
35. Latter Day Saints Student Center
36. Health Center
37. Combs Hall (Cardinal Village III)
38. Wesley Foundation Methodist Center
39. Baptist Student Center
40. Dining Hall
41. Texas Success Initiative/Developmental Studies (former ROTC Bldg.)
42. Maes
43. Gentry Hall (Cardinal Village I)
44. Morris Hall (Cardinal Village II)
45. Education
46. Hydraulics Lab
47. Speech and Hearing
48. Monroe Hall (Cardinal Village V)
49. Campbell Hall (Cardinal Village IV)
50. John Gray Center University Advancement
51. Admissions Visitors Center
52. Brooks-Shivers Hall
53. Human Resources
54. Golf Driving Range
55. Vincent-Beck Stadium
56. Soccer and Softball Complex

E. Lavaca

M.L. King Pkwy

E. Virginia

E. Virginia

Alabama

Georgia

Iowa

Jimmy Simmons Boulevard

Rolfe Christopher

Jim Gilligan Way

Lamar Institute of Technology



**DEPARTMENT
OF
SPEECH & HEARING
SCIENCES**

Lamar University

Mission Statement

The Department of Speech and Hearing Sciences engages and empowers a diverse student population in the acquisition of knowledge and skills through innovative and interactive curriculum design, faculty mentored research, exceptional clinical service delivery, and dedicated outreach to the community. Through these transformative activities the Department of Speech and Hearing Sciences provides interdisciplinary collaboration regionally and globally.

CONTACT:

PHONE:
409-880-8338

WEBSITE:
www.lamar.edu/speechandhearing

SPHS Executive Summary

- A. STRATEGIC GOAL: Enhance access to SPHS's educational programs and student services
 - a. Objective 1: To strengthen student support
 - b. Objective 2: To develop innovative course work and teaching methods
- B. STRATEGIC GOAL: Leverage core strengths while elevating the overall quality of education and scholarship
 - a. Objective 1: To grow and support top researchers and creative scholars
 - b. Objective 2: To ensure equitable workload distribution and salaries
 - c. Objective 3: To establish common areas for program development across disciplines
- C. STRATEGIC GOAL: Develop a leading-edge environment
 - a. Objective 1: To develop forward-looking academic programs, program outcomes, and facilities
 - b. Objective 2: To encourage innovative and cutting-edge research and clinical activity
 - c. Objective 3: To improve organizational policy and processes workflow to accelerate output and efficiency
- D. STRATEGIC GOAL: Enhance data-based systems, metrics, and reporting procedures
 - a. Objective 1: To promote use of departmental data to improve enrollment and graduation rate
 - b. Objective 2: To promote use of data to improve faculty and staff performance
 - c. Objective 3: To use data for assessment of learning outcomes
 - d. Objective 4: To use clinic data for assessment of learning outcomes
- E. STRATEGIC GOAL: Tell our SPHS departmental story to connect the communities we serve with our mission, accomplishments and aspirations
 - a. Objective 1: To tell our story locally
 - b. Objective 2: To tell our story nationally and internationally
 - c. Objective 3: To engage regional professionals with students/faculty