



## **Auditory Processing Disorder (APD) Evaluation**

Your child has been scheduled for an APD evaluation. The assessment will be completed in two separate visits to this Center. Enclosed you will find forms for the child's primary caregiver to fill out. These forms should be completed prior to the first appointment. Should you decide to mail these documents, please copies for yourself. Please bring copies of any other evaluations your child may have had such as speech, language, or educational testing reports.

### **Preparing Your Child for the Appointment**

In order to prepare your child for the appointment, you may want to tell him/her that he/she is going to see an audiologist who is going to check to see how well he/she hears. You may want to avoid using the word "test," as this causes anxiety in some children.

### **First Appointment**

APD tests are not administered at the first visit. This is mainly an appointment at which your child's hearing will be thoroughly evaluated, and the audiologist will talk with you to determine if your child is indeed a candidate for an APD evaluation. This appointment is booked for two hours.

### **Second Appointment**

The length of this appointment will depend on your child's attention span and performance on the APD tests. Typically, the appointment is booked for two hours. Make sure your child gets plenty of rest and a healthy meal or snack prior to the evaluation so he/she is ready to work when they arrive. Please be aware that candy and soda may encourage hyperactivity, which may reduce productivity. Sometimes there may be a brief waiting period; so, it would be a good idea to bring some activities to occupy your child.

### **Medications**

If your child is on medication for ADD or ADHD, it is very important that they take their medication on the day of the test. This will help him/her to attend appropriately.

### **When NOT to Bring Your Child to an Appointment**

If your child has an ear infection, serious sinus problem, or active illness, we CANNOT test him/her. Please call and notify this Center if you need to reschedule this appointment.

We look forward to seeing you and your child. Please do not hesitate to contact us at (865) 769 – 0283 if you have any questions.



## Registration and Consent

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Sex: Male/Female Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Who may we contact in case of an emergency? \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Who may we thank for referring you to Bridgewater? \_\_\_\_\_

Who is financially responsible for the bill? \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**I authorize Bridgewater Balance and Hearing, Inc. to release information requested with regard to processing my claims. Yes or No**

**I authorize Bridgewater to disclose any or all parts of my protected health information to the individuals listed below. I acknowledge this with my signature within the Patient's Benefit Assignment, Privacy Notice, and Contact Authorization below:**

Contact Preference: \_\_\_ Confidential \_\_\_ Do NOT call \_\_\_ Okay to Leave Message \_\_\_ E-Mail

The evaluation and treatment procedures by Bridgewater clinicians are professionally and ethically acceptable and offer no probable physical or psychological risk. Although procedures are expected to be of benefit, I understand that no guarantee of success can be expressed or implied. I agree to the scheduled procedures and understand I may discontinue the evaluation or treatment at any time.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. All registration information is correct to the best of my knowledge. I will notify Bridgewater Balance and Hearing, Inc. should the above information change.

**Privacy Notice:** I confirm that I have been given a copy of the Bridgewater Balance and Hearing's Notice of Privacy Policies and understand my privacy rights.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature (if Patient is a minor): \_\_\_\_\_



## Financial Responsibility for the Cost of Services

**Insured Name (Print Clearly):** \_\_\_\_\_ **Insured's Date of Birth:** \_\_\_\_\_

**Please List Primary and Secondary Insurances Below:**

Primary Insurance Company Name	Member ID Number	Date of Birth
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Secondary Insurance Company Name	Member ID Number	Date of Birth
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**Name of Primary Care Physician:** \_\_\_\_\_

**Services Requested: Auditory, Vestibular, and/or Diagnostic Evaluations**

I know that commercial and state sponsored insurances pay for healthcare. I know when I get health care, my doctor sends the charges to my insurance company for payment. I know I must show my ID card to all doctors and hospitals before I get health care. I know a copayment is when I have to pay part of the bill each time I receive certain health care services. **I know that it is my responsibility to get all insurance authorizations in advance.**

**Please initial each statement below that applies to you:**

\_\_\_\_\_ **I have Medicare, Medicaid, or TENNCARE. I asked for one or more of the health care service(s) listed below. I understand my insurance may not pay for it.**  
 \*A physician referral is **REQUIRED** to bill Medicare.

\_\_\_\_\_ **I have private commercial insurance. I asked for one or more of the health service(s) listed below. I understand my insurance may not pay for it.**

My doctor has told me how much of the health care service(s), listed below, I may have to pay.  
**Balances listed below may be added to any applicable deductibles. I must pay my balance in a timely manner in order for the discounted amount to remain in force.**  
**The patient is also responsible for any balance listed as patient responsibility.**  
 This is a legal and binding contract.

Service	Cost of Service	Patient Balance is NOT to Exceed:
Specialist New Patient Office Visit	\$125.00	\$125.00
Audiometric (Hearing) Evaluation	\$335.00	\$215.00
Auditory Processing (APD) Evaluation	\$1275.00	\$595.00
EcochG and ABR Evaluation	\$850.00	\$395.00
VNG Evaluation	\$1200.00	\$595.00
Hearing Instruments**	As Indicated	The patient agrees to pay all balances.

\*\* If you request that Bridgewater Balance and Hearing bills your insurance company for hearing instruments, the PATIENT is responsible for all hearing aid balances over the *actual insurance reimbursement amount* of the devices.  
 \*\* If you request that Bridgewater Balance and Hearing files your claim, provider write-off and discount amounts are NOT applicable on hearing instrument purchases.  
 \*\* Patients that choose to purchase hearing instruments that EXCEED the amount of insurance coverage on their plan do so with the understanding that they agree to pay ALL BALANCES over the *actual insurance reimbursement amount*.

**By signing this paper, I agree to pay for the services listed above in a timely manner.**

\_\_\_\_\_  
**Printed Name of the Responsible Person**

\_\_\_\_\_  
**Signature of Member or Responsible Person**



## Hearing and APD Fee Policy

The following services are the typical billing codes for hearing and APD testing. Once the audiologist obtains the case history, appropriate tests will be administered.

**PLEASE ALLOW AT LEAST 2 HOURS FOR EACH of TWO APPOINTMENTS FOR THIS COMPLETE TEST BATTERY.**

Diagnostic Codes: 388.43

CPT Code	Office Service
99203	New Patient Office Visit
92557	Comprehensive Audiometry Threshold Evaluation and Speech Recognition
92550	Tympanometry and Acoustic Reflex Thresholds
92558	Distortion Product Otoacoustic Emissions
92585	Auditory Evoked Potentials (e.g., ABR)
92620	Evaluation of Central Auditory Function (Initial 60 Minutes)
92621	Each Additional 15 Minutes (3 Units)

Bridgewater will file a claim with your insurance company for all testing; however, you may be responsible for the remaining balance.

**It is the patient's responsibility to contact his/her insurance company to determine if the services to be conducted are covered.**

For CIGNA insurance, Bridgewater is credentialed as an "Ancillary Provider" and therefore covered under the corporation Bridgewater Speech and Hearing.

The cost of services billed for this series of assessments is approximately \$1,275.00. The patient responsibility will be no more than \$595.00 *after* insurance reimbursement.

Some insurance companies require pre-authorization for this testing. Your primary care physician can assist you in obtaining the correct authorization.

Thank you,

Brittany Bach  
Office Manager



## Record Release

I authorize Bridgewater Balance and Hearing to issue  
my hearing healthcare information to:

\_\_\_ Physician(s): \_\_\_\_\_

\_\_\_ Insurance Company: \_\_\_\_\_

\_\_\_ Other(s): \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## Release of Records from Another Healthcare Provider

I authorize a release of my hearing and balance records to  
Bridgewater Balance and Hearing from:

\_\_\_\_\_  
Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Please Fax Records to:

\_\_\_ Knoxville Office at (865) 769-0281

\_\_\_ Sevierville Office at (865) 429-0719





## Patient History

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

School Name: \_\_\_\_\_

Teacher's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Primary Reason for Referral: \_\_\_\_\_

Why do you think your child may have an auditory processing disorder? \_\_\_\_\_

Do you want your child present in the room when the APD test results are reviewed?  Yes  No

Is your child right- or left-handed?  Right-Handed  Left-Handed

How many weeks was the pregnancy with this child? \_\_\_\_\_

Were there any complications, illnesses, or infections during the pregnancy or at birth?  Yes  No

If yes, please explain: \_\_\_\_\_

Please check if you had any of the following during the pregnancy with this child:

Rubella  Syphilis  Herpes  Cytomegalovirus (CMV)  Toxoplasmosis  Other

Cesarean-section?  Yes  No Child's Birth Weight: \_\_\_\_\_ APGAR Scores: \_\_\_\_\_

Did your child need oxygen at birth?  Yes  No If yes, for how long? \_\_\_\_\_

Did your child need phototherapy at birth?  Yes  No If yes, for how long? \_\_\_\_\_

Was your child in the NICU?  Yes  No If yes, for how long? \_\_\_\_\_

Did your child pass his/her hearing screening in both ears at birth?  Yes  No

Has your child had his/her hearing tested by an audiologist?  Yes  No

If yes, when? \_\_\_\_\_ By whom? \_\_\_\_\_ What were the results? \_\_\_\_\_

Does your child have any permanent hearing loss?  Yes  No

If yes, please explain: \_\_\_\_\_

Is there a family history of hearing loss?  Yes  No

If yes, please explain: \_\_\_\_\_

Does your child have difficulty hearing when there is background noise present?  Yes  No

Has your child ever used hearing aids or any other amplification (e.g., FM system)?  Yes  No

How many ear infections has your child had at: 0 -12 mos \_\_\_\_\_ 12mo-5 yrs \_\_\_\_\_ 5 yrs – present: \_\_\_\_\_

When was his/her most recent ear infection? \_\_\_\_\_ How was it treated? \_\_\_\_\_

Has your child ever had tubes in his/her ears?  Yes  No If yes, when? \_\_\_\_\_

Has your child ever had any other ear surgery?  Yes  No If yes, please explain: \_\_\_\_\_



Please check any of the following that apply:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Trauma to the head or ear          | <input type="checkbox"/> Dizziness or clumsiness       | <input type="checkbox"/> Jaundice            |
| <input type="checkbox"/> Excessive noise exposure           | <input type="checkbox"/> High Fever (over 102°F)       | <input type="checkbox"/> Meningitis          |
| <input type="checkbox"/> Blood Transfusion                  | <input type="checkbox"/> Attention Difficulties        | <input type="checkbox"/> Diabetes            |
| <input type="checkbox"/> Kidney Problems                    | <input type="checkbox"/> Heart Problems                | <input type="checkbox"/> Vision Problems     |
| <input type="checkbox"/> Allergies                          | <input type="checkbox"/> Frequent Runny Nose           | <input type="checkbox"/> Easily Distractible |
| <input type="checkbox"/> Frequent Colds or Sinus infections | <input type="checkbox"/> Ringing/Buzzing in the ear(s) | <input type="checkbox"/> CT/MRI              |

Has your child had any serious accidents or illnesses? If yes, please explain: \_\_\_\_\_

Has your child been diagnosed with any developmental delays, disorders, or syndromes – including ADD, ADHD, or any learning disorders?  Yes  No If yes, please explain: \_\_\_\_\_

Is your child’s speech and language age-appropriate?  Yes  No

Is he/she enrolled in speech and/or language therapy?  Yes  No

If yes, please describe where and how often: \_\_\_\_\_

Is there a family history of learning and/or attention problems?  Yes  No

If yes, please explain: \_\_\_\_\_

What type of classroom (e.g., mainstream, special education) is your child enrolled?

Please explain: \_\_\_\_\_

Has your child ever repeated a grade?  Yes  No If yes, please explain: \_\_\_\_\_

Please list any special services your child is receiving at school or privately. Please give the service (e.g., OT, PT, tutoring), frequency of services, and duration of each visit. \_\_\_\_\_

How is your child doing in the following subjects? Please indicate if your child is at, below, or above grade level in each area.

Subject	At	Below	Above	Comments
Math	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reading Comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Music	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Subjects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____



Please check if your child has been evaluated by any of the following specialists:

- Speech-Language Pathologist  Psychologist  Occupational Therapist  Physical Therapist

If yes, please explain when, by whom, and the outcome: \_\_\_\_\_

Does your child have a current Individualized Education Plan (IEP)?  Yes  No

If yes, what is the primary diagnosis? \_\_\_\_\_

If yes, what is the rollover date? \_\_\_\_\_

If no, do they have a 540 plan?  Yes  No

If yes, what is the primary diagnosis? \_\_\_\_\_

### **Auditory Processing Disorder (APD) Symptoms and Subtypes**

The following checklists are drawn from a history questionnaire composed by Judith W. Paton, M.A., Audiologist, and Bonnie G. Rattner, Ed.D., Speech-Language Pathologist.

Please check all symptoms that your child exhibits.

#### **Tolerance/Fading Memory Type APD**

- Often seems to ignore people, especially if engrossed in an activity
- Hears less well, or is less attentive or productive, in ordinarily busy surroundings
- Difficulty following a series of spoken directions
- Unusually forgetful of information previously memorized (e.g., multiplication tables, correct spellings) or of household or school routines and responsibilities, despite frequent reminders

#### **Decoding-Subtype APD**

- Difficulty with phonics (sounding out words) approach to reading
- Confuses similar-sounding words; may learn words wrong
- Poor speller:
  - Errors phonetically correct (e.g., “littul” for little)
  - Errors seem random (wrong sounds, sounds or syllables are missing or added)
- Problems with speech clarity or articulation, or with grammar, now or in the past

#### **Integration-Type APD**

- Marked difficulty reading or writing efficiently, despite knowledge of phonics
- Needs to ask many extra questions to clarify a task before starting; doesn't see the “big picture”
- Interprets words too literally, becoming confused or suffering hurt feelings
- Poor communicator – fails to explain, apologize, negotiate, and/or defend
- Speaks or writes telegraphically – omits facts or switches topic such that the audience cannot follow

#### **Prosodic-Type APD**

- Absorbs details and facts, but missed the “big picture”; cannot prioritize or summarize information
- Insensitive to tone of voice; may misjudge a speaker's mood or be unintentionally tactless
- Problems with cause-and-effect reasoning; difficulty surmising the unspoken rules of conversation, play, and other situations



## Fisher's Auditory Problems Checklist

Patient Name: \_\_\_\_\_ District/Building \_\_\_\_\_

Date: \_\_\_\_\_ Grade: \_\_\_\_\_ Observer: \_\_\_\_\_ Position: \_\_\_\_\_

Please place a checkmark before each item that is considered to be a concern by the observer:

- 1. Has a history of hearing loss
- 2. Has a history of ear infections
- 3. Does not pay attention (listen) to instruction 50% or more of the time
- 4. Does not listen carefully to directions – often necessary to repeat instructions
- 5. Says “Huh?” and “What?” at least five times per day.
- 6. Cannot attend to auditory stimuli for more than a few seconds
- 7. Has a short attention span
  - 0 – 2 minutes
  - 2 – 5 minutes
  - 5 – 15 minutes
  - 15 – 30 minutes
- 8. Daydreams – attention drifts – not with it at times
- 9. Is easily distracted by background sound(s)
- 10. Has difficulty with phonics
- 11. Experiences problems with sound discrimination
- 12. Forgets what is said in a few minutes
- 13. Does not remember simple routine things from day to day
- 14. Displays problems recalling what was heard last week, month, year
- 15. Has difficulty recalling a sequence that has been heard
- 16. Experiences difficulty following auditory directions
- 17. Frequently misunderstands what is said
- 18. Does not comprehend many words – verbal concepts for age/grade level
- 19. Learns poorly through the auditory channel
- 20. Has a language problem (morphology, syntax, vocabulary, phonology)
- 21. Has an articulation (phonology) problem
- 22. Cannot always relate what is heard to what is seen
- 23. Lacks motivation to learn
- 24. Displays slow or delayed response to verbal stimuli
- 25. Demonstrates below average performance in one or more academic area(s).

Scoring: Four percent credit for each numbered item not checked.

Number of items not checked: \_\_\_\_\_ x 4 = \_\_\_\_\_

Normative data-grade score from reverse side: \_\_\_\_\_