Weill Cornell Medicine
Hearing & Speech Center

Yvonne Knapp, MS, CCC/SLP

Adult Case History Form

GENERAL INFORMATION			
Name:			Date of Birth:
Address:			
City:	State:	Zip Code:	Telephone:
Occupation:			
Family Physician:			
Address:			
Single ❒ Widowed ❒	Divorced ❒	Spouse's Name:	
Referred by:			
Address:			
Diagnosis:			
Reason for Referral:			
Do you have children? *(include names, gender and ages)*			
Who lives in the home?			

What languages do you speak? If more than one, which one is your dominate language?
EDUCATIONAL/VOCATIONAL HISTORY
Occupation:
Are you currently employed?
If no, how long have you been unemployed?
Are you planning to return to some kind of work?
What leisure activities do you enjoy?

DESCRIPTION OF THE PROBLEM
Describe the problem:
When did you first notice this problem? Was the onset slow or gradual? Can you connect onset with any particular event?
What, if anything do you think may have caused the problem?
Has the problem changed since it was first noticed?
Does the problem vary? What makes the problem better or worse?
Have you seen any other speech pathologist? Who and when? What were their conclusions or suggestions?
Are you a performer (i.e. actor, singer)? If yes, please describe:

Have you had any previous voice training?			
How would you describe your hearing? *(with aids, if applicable)*			
Excellent ❒ Good ❒ Fair ❒ Poor ❒			
Has your hearing been evaluations? Yes ❒ No ❒			
If yes, when:			
By whom:			
Do you smoke?	Yes ❒	No ❒	
If yes, how much?		For how long?	
If you have stopped, when?			
Have you adopted any methods on your own that seem to help your problem?			
How has the problem affected your job, school, personal or social life?			
Have you seen any other medical specialists (physicians, psychologist, neurologists, etc.)? If yes, indicate the type of specialist, when you were seen, and the specialist's conclusions or suggestions.			

What would your improved voice enable you to do that you are not currently doing?

MEDICAL HISTORY

Provide the approximate ages at which you suffered the following illnesses and conditions.

Adenoidectomy	Asthma	Nasal Congestion
Colds	Croup	Deviated Nasal Septum
Draining ear	Ear Infections	Diabetes
Hiatal Hernia	Headaches	Hearing Loss
High Fever	Influenza	Peptic Ulcer Disease
Gastroesophageal Reflux	Obesity	Pneumonia
Seizures	Post-nasal drip	Tonsillitis
Tonsillectomy	Sinusitis	Other

Other chronic and/or serious illnesses:

Other chronic respiratory problems:

Do you have any eating or swallowing difficulties? If yes, describe.

Do you ever experience nasal regurgitation (leakage of liquids and/or solids through your nose)?
List all medications you are taking and how often you take them.
Are you having any negative reactions to these medications? If yes, describe.
Describe any major illnesses, surgeries, operations, or hospitalizations (include dates)
Describe any allergies:
Describe any major accidents:
On a scale of 1 to 10, one being the lowest, how would you rate your stress level?

Provide any additional information that might be helpful in the evaluation or remediation process.
Person completing form:
Relationship to client:

Sign	Date
Yvonne Knapp, MS, CCC/SLP	Date

Weill Cornell Medicine

Department of Otolaryngology –
Head and Neck Surgery

Financial Policy

Welcome to the Department of Otolaryngology-Head & Neck Surgery.
The following is a statement of our financial policy. We hope this gives you a better understanding of how our billing works.

Financial Policy

Patients have many different types of insurance and payment options for services rendered. Also, not all physicians in the practice accept the same type of insurance. The three most common scenarios are outlined below. Please read the following and if you have any question or concerns please call the office of the physician you are seeing.

Participating Plans

In this scenario the physician you will see participates with your insurance plan. It is your responsibility to ensure your physician is in fact currently a provider in that plan. At the time of service you will be responsible for all co-payments and co-insurances as outlined by your plan coverage. We will collect your co-insurances and deductibles in advance if you are having a procedure in the office or hospital. The Medical College will then forward a bill to your insurance carrier who will confirm if any additional payments are due from you. You will receive written notification of such decision and may ultimately be responsible for such payments as determined by your insurance company. If your plan requires a referral, please present the referral at the time you check-in. If you do not have a referral you may have to reschedule your appointment.

Non-Participating Plans

In this scenario the physician you will see does not participate in you insurance plan. Payment of services is due at the time of the visit. We can submit the claim directly to your carrier or a claim can be mailed directly to you.

Medicare

For any of our providers that participate with Medicare, we will bill Medicare directly for your service and Medicare will send payment directly to the physician. You will be responsible for any deductible or co-insurance. If your physician does not participate with Medicare you will be responsible for payment at the time of service, and your claim will then be forwarded to Medicare and they will reimburse you directly.

Usual and Customary Rates

Your insurance policy is a contract between you and your insurance company. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Payment

Cash, Check, MasterCard, Visa, Discover and American Express card are recognized forms of payment.

We hope this information is helpful; Again, if you have any questions or concerns, please contact your physician's office.

Signature of Patient or Responsible Party **Date**